Recovery Works

INDIANA'S FORENSIC TREATMENT PROGRAM

Policies and Procedures Manual

October 2019 Edition 6

Dear Provider,

It is our great pleasure to welcome you to Recovery Works. This program is designed to provide support services to those without insurance coverage who are involved with the criminal justice system. Recovery Works is a gap funding program, to be used until the individual is connected to insurance. Recovery Works is dedicated to increasing the availability of specialized treatment and recovery services in the community for those who may otherwise face incarceration. Treatment and/or recovery services are intended to supplement community supervision strategies to decrease recidivism.

In order to help facilitate a successful program, this manual has been produced as a ready reference for providers. The manual contains all of the policies and procedures for Recovery Works in Indiana. This resource will continually evolve over the life of the program, and updates will be issued as needed. **It is imperative for providers to insert all policy and procedure memos that are issued by DMHA and, when directed, to replace the full contents with the newest version of the manual.**

The program staff is dedicated to providing the support you need to successfully implement Recovery Works at your agency and in your community. Please do not hesitate to contact us at Recovery.Works@fssa.IN.gov when you have questions or concerns about the program. Thank you for joining the Recovery Works network and providing participants with an opportunity for a brighter future.

Sincerely,

Recovery Works Program Staff

Throughout the manual you will note sections that are highlighted in gray. These areas have been changed or added since the last edition. Please take time to thoroughly review these sections.

Recovery Works Program Policies

BACKGROUND

Within the general public, the prevalence rate of people who have a serious mental illness or substance use disorder is 18.1% and 8.4%, respectively. Of the current prison population, 56% of state and 45% of federal prison inmates have a diagnosed serious mental illness. Just under three-quarters of those are incarcerated in our state prisons (74%), and just under two-thirds (64%) in our federal prisons, have a substance use disorder diagnosis. Of the population who return to prison, the percentage of persons with a substance use disorder reaches 75%. There is a prevailing need for a partnership between the criminal justice system and mental health and substance use service providers, in order to reduce recidivism and encourage recovery.

In 2012, the Council of State Governments Justice Center (CSGJC) prepared a white paper titled "Adults with behavioral health needs under correctional supervision: a shared framework for reducing recidivism and promoting recovery," which provided an outline on how corrections, mental health and substance use disorder systems can share a commitment to help individuals successfully address their needs and avoid criminal justice involvement. In 2015, the Indiana General Assembly passed House Enrolled Act (HEA) 1006, "Criminal Justice Funding," which established the Forensic Treatment Services Program through the Division of Mental Health and Addiction (DMHA). This program will fund a voucher-based program to providers that offer specialized services to those struggling with mental illness and/or Substance Use Disorder (SUD). This voucher-based system is intended to cover the cost of services for individuals without any alternate payer source (private insurance, Medicaid, and/or HIP etc.). HEA 1006 granted $10 million for the 2016 state fiscal year of the program, and $20 million for the 2017, 2018 and 2019 state fiscal years. This voucher program, referred to as Recovery Works, will work with entities that are DMHA certified and/or housing providers who demonstrate competency in the treatment of populations with criminogenic risk factors.

Predictions based on the changes in criminal code from HEA 1006 estimate that approximately 6,500 low level offenders will now need services within the community, rather than being sent to a correctional facility. Recovery Works focuses on pre-incarceration diversion services and post-incarceration re-entry services, which not only hopes to divert low-level offenders from incarceration to community services, but to reduce recidivism as well. Promoting recovery through community support and treatment/intervention is critical in reducing the number of persons with mental health and/or Substance Use Disorder that are entering our criminal justice system.

WHAT IS RECOVERY?

In December 2011, Substance Abuse Mental Health Services Administration (SAMHSA) released a working definition of recovery and a set of guiding principles. This definition was the result of a comprehensive process that began with an August 2010 Dialogue Meeting and ended with a formal public engagement process in August 2011. At the time SAMHSA released the working

definition, SAMHSA indicated they would continue dialogue to refine the definition and principles, and based on additional stakeholder input, SAMHSA then issued a slightly revised definition:

Recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Four major dimensions that support a life in recovery:

- ***Health:*** overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has Substance Use Disorder problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

GUIDING PRINCIPLES OF RECOVERY

- ***Recovery emerges from hope:*** The belief that recovery is real provides the essential and motivating message of a better future: one where people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.
- ***Recovery is person-driven:*** Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.
- ***Recovery occurs via many pathways:*** Individuals are unique with distinct needs, strengths, preferences, goals, cultures, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment, use of medications, and support from families and in schools, faith-based approaches, peer support, and other approaches. Recovery is non-linear, characterized by continual growth and improved

functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with Substance Use Disorder (SUD). Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

- ***Recovery is holistic:*** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and Substance Use Disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.
- ***Recovery is supported by peers and allies:*** Mutual support and mutual aid groups, including social learning and the sharing of experiential knowledge and skills, play an invaluable role in recovery. Peers encourage and engage other peers by providing each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.
- ***Recovery is supported through relationships and social networks:*** An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, and employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.
- ***Recovery is culturally-based and influenced:*** Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are key in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.
- ***Recovery is supported by addressing trauma:*** The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated

with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

- ***Recovery involves individual, family, and community strengths and responsibility:*** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for his or herself. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have a responsibility to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility, and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.
- ***Recovery is based on respect:*** Community, systems, and a societal acceptance and appreciation for people affected by mental health and substance use problems —including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

It is important to keep the Principles of Recovery in mind when working with your participant on his/her recovery journey. While we understand, for some participants, choices may be limited; we do encourage participant choice through the individualized recovery planning processes as much as possible. When an individual is empowered to drive his/her own recovery process by choosing services they feel will be most beneficial to them, it allows the participant to begin to gain or regain control over their life. This self-determination and/or self-direction is one of the guiding principles of recovery.

MOTIVATIONAL INTERVIEWING

A recovery-oriented system of care is participant driven. Motivational Interviewing, one vehicle used in a recovery-oriented system, supports the relationship between a participant and a provider by empowering participants in their own recovery. Motivational interviewing can be utilized to help participants realize the discrepancies in their thought processes and then begin to move toward reaching their individual goals. Motivational interviewing focuses on exploring and resolving participants' ambivalence and centers on the motivational processes (what motivates this particular person) to bring about change.

Motivational Interviewing has three key elements: collaboration between the provider and the participant, evoking the participant's ideas about change, and emphasizing the autonomy of the participant. These key elements are both participant-focused and participant-driven, which

enables motivational interviewing to be utilized in a recovery-oriented system of care.

There are four principles employed by providers using Motivational Interviewing. Any of these principles functioning on its own can be ineffective, but when they are implemented together, they can effectively help participants move through the stages of change.

The principles are:

1. **Express Empathy**: Expressing empathy involves seeing, feeling, and thinking about things the way in which the participant does. This expression helps participants sense their providers understand them individually and that they also care about the personal issues they are facing. This tends to promote the participant being more open and honest with providers and thereby allowing for a more workable and helpful relationship to develop.
2. **Develop Discrepancy**: Developing discrepancy occurs when participants see the mismatch between where they are in life and where they want to be. When participants identify discrepancy between their current behaviors/circumstances and their values and plans the likelihood that they will become more motivated increases. Providers do not point out discrepancies, but help participants see inconsistencies that may exist by asking questions.
3. **Roll with Resistance**: Rolling with resistance discourages providers from confronting participants when they begin to resist the change process. Actions and statements that show resistance remain unchallenged. By having the participant define the problem and develop their own solutions, there is little room for resistance. Providers can go along with what participants say, and then utilize these statements to help them develop discrepancy.
4. **Support Self Efficacy**: Supporting self-efficacy is about encouraging participants to believe that change is possible. This approach credits participants with having the capacity and capability to change. This idea generates hope and allows participants who have previously tried recovery and failed to believe that success is possible. Self-efficacy is supported by highlighting participants' strengths instead of their failures.

Recovery Works requires that providers utilize Motivational Interviewing techniques to encourage and empower participants to enter and stay in recovery. The principles and elements of Motivational Interviewing support a recovery-oriented approach and a participant/provider partnership that will allow participants to be successful in maintaining their recovery. In addition, all direct services providers must attend an in person Motivational Interview training within 90 days of hire. For more information, visit http://motivationalinterview.net/.

VISION

Every person should have the opportunity to live a healthy, hopeful, fulfilled life in the community. Recovery Works provides community based interventions that ensure both the safety of the community and the recovery of the individual needing treatment rather than incarceration.

VALUES

Decency: all people should be treated with respect and their needs responded to quickly

Fortitude: never giving up

Hope: a positive future view

Integrity: do the right thing even when no one is looking

Parity: every person deserves the same opportunity

Quality: service should be of the highest caliber

PROGRAM POLICIES

SERVICE ETHICS

Recovery Works Providers agree to abide by the following service ethics when serving Recovery Works participants:

1. *Effective recovery support and treatment attend to the whole person, not just his or her illness.* To be effective, all components of recovery must be considered and each area of life, including social, vocational, educational, physical and mental health, and environment must be assessed for strengths and addressed appropriately. Not everyone's recovery looks the same; therefore, not everyone's recovery plan should look the same. It is imperative that the whole person be addressed and each barrier to recovery planned for. It is equally imperative that providers utilize an individualized treatment approach, as opposed to a "one size fits all" approach.
2. *The participants' recovery process is their own.* There is no one path to recovery and no one service that is appropriate for every individual. The participants' services need to be tailored to their individual needs and strengths. This means services need to be appropriate for the stage of recovery a participant is in and should be driven by the participant. Remember, providers are not the experts in relation to participants' personal lives and struggles; therefore, their recovery should be approached as a partnership and not as an expert/consumer or teacher/student relationship.

3. *An individual's recovery plan must be assessed continually and modified regularly to ensure that the plan meets the person's changing needs*. A person may require varying combinations of services, both clinical and recovery support, during the course of recovery. It is vital that Recovery Works services be appropriate to the individual's age, gender, ethnicity, language, culture, and stage in his or her recovery. If a participant's plan is not changing, then the plan is not working. A participant should be making progress throughout their involvement with the program and therefore, will not have the same needs throughout. It is important to keep up with a participant's progress to ensure that he or she is offered the most pertinent services at the right time. At no time should a participant receive services because "everyone else receives this service."
4. *To promote recovery, it is necessary to maintain services for however long they are needed.* This will depend on each individual participant's needs and will require a vast array of coordinating, funding sources and partners as Recovery Works funding is limited. It is important that providers and participants understand that Recovery Works will not be able to fund everything participants need. Therefore, knowing the services available locally and helping participants access them is important. Each community has programs and resources that are available at low or no cost to participants and these can, and should, be utilized to help facilitate the continuation of recovery after Recovery Works funding is used. If you are unsure of the resources in your area, you can contact 2-1-1 for assistance in familiarizing yourself with available community resources.
5. *All documentation must be complete and accurate.* This includes, but is not limited to, the length of encounters with participants (no rounding up is permitted, only actual times will be recorded), who rendered the service, individual contribution to the service etc. If documentation is not accurate and complete, it can be deemed fraud and may result in termination of contract and/or prosecution. In addition, files must be organized and legible.

CONFIDENTIALITY

Confidentiality of participant information is an ethical obligation for all providers and a legal right for every participant. Providers may have access to confidential information regarding alcohol and substance use disorder patient records. Recovery Works providers agree that such information is confidential and promises to ensure that any such information, regardless of form, disclosed to the provider for the purposes of this program will not be disclosed or discussed with others without the prior written consent of the participant. Recovery Works providers must comply with confidentiality of participant information and protected health information requirements as set forth in HIPAA, 42 CFR Part 2, IC 16-39, and any other state or federal regulations. Providers must obtain a completed release of information from each Recovery Works participant, and for each party to whom information is disclosed. This includes a release to communicate with criminal justice partners.

Providers should use the unique participant identification number assigned by WITS when referring to Recovery Works participants in written communications, including e-mail. The provider may not disclose protected health information in e-mail communications.

PROVIDER AND CONSUMER COMPLAINTS

All complaints should be submitted to the DMHA Consumer Service Line (1-800-901-1133). Each complaint received will be forwarded and reviewed by Recovery Works staff. If further information is needed to complete a thorough investigation, Recovery Works staff will contact the complainant for additional information. This Consumer Service Line extends to participants in the program who have complaints regarding Recovery Works.

PROGRAM COMPLIANCE WITH HEALTH AND SAFETY REGULATIONS

Recovery Works Providers must serve all participants in safe facilities. Facilities used by a program are required by law to be in compliance with fire and safety standards established and enforced by local and state fire officials. Also, all health, safety, and occupational codes must be met at the local level.

Programs must meet all the requirements of the Americans with Disabilities Act of 1990. The ADA requirements state that all sites should be accessible to the disabled in the greatest extent feasible and during renovations and new construction, certain standards must be met. For existing structures, any changes that increase accessibility without changing the fundamental structural viability of the facility must be planned and implemented in a timely and diligent manner.

SERVICE CHANGES

Designated Recovery Works agencies may only claim for services that they provide directly and that have been identified on their application. As such, each agency must ensure they are accurately identifying the services for which their agency is qualified. If a designated Recovery Works agency would like to change a recovery support or clinical service that is being offered, for which voucher reimbursement is requested, an application addendum is required. Notification of changes must be submitted to RW prior to the new services being rendered. For example, if the agency would like to add or remove a current service being offered, an application addendum would be required. If there is a change or addition to the geographical location where such services are provided, an application addendum is required. This also extends to new housing locations that are offered. The Division of Mental Health and Addiction maintains responsibility for approving application addendums. DMHA must be contacted in the event that an agency would like to provide additional Recovery Works services or change facility information. All addendums must be submitted and approved by DMHA designated staff prior to implementing changes.

STAFF CHANGES

Providers shall inform Recovery Works administration of staff changes within ten (10) business days of said change. This policy shall apply to vacancies as well as new hires and changes in responsibility; but shall only apply to positions that have responsibilities that include provision or supervision of the provider's Recovery Works services (example: administrative staff that have access to WITS, clinical staff, rendering staff). For staff with WITS access, a WITS Access Spreadsheet must be submitted to notify Recovery Works administration staff of needed changes in the WITS system. Failure to notify Recovery Works will result in a 30 day suspension of billing privileges and/or reimbursement of services for staff who may have provided services.

DRUG- FREE WORKPLACE

Providers hereby covenant and agree to make a good faith effort to provide and maintain drug free workplaces. Providers will give written notice to the State within ten (10) days after receiving actual notice that they or one of their employees have been convicted of a new criminal drug violation. False certification or violation of this Agreement may result in sanctions including, but not limited to, suspension and/or termination of the Provider Agreement. Providers certify and agree that they will provide a drug-free workplace by:

A. Publishing and providing to all of its employees a statement notifying them that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the provider's workplace, and specifying the actions that will be taken against employees for violations of such prohibition;

B. Establishing a drug-free awareness program to inform its employees of (1) the dangers of Substance Use Disorder in the workplace; (2) the provider's policy of maintaining a drug-free workplace; (3) any available Substance Use Disorder counseling, rehabilitation and employee assistance programs; and (4) the penalties that may be imposed upon an employee for Substance Use Disorder violations occurring in the workplace;

C. Notifying all employees in the statement required by subparagraph (A) above that as a condition of continued employment, the employee will (1) abide by the terms of the statement; and (2) notify the provider of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

D. Notifying the State in writing within ten (10) days after receiving notice from an employee under subdivision (C)(2) above, or otherwise receiving actual notice of such conviction;

E. Within thirty (30) days after receiving notice under subdivision (C)(2) above of a conviction, imposing the following sanctions or remedial measures on any employee who is convicted of substance use violations occurring in the workplace: (1) taking appropriate personnel action

against the employee, up to and including termination; or (2) requiring such employees to satisfactorily participate in a Substance Use Disorder assistance or rehabilitation program approved for such purposes by a federal, state or local health, law enforcement, or other appropriate agency; and

F. Making a good faith effort to maintain a drug-free workplace through the implementation of subparagraphs (A) through (E) above.

CONFLICT OF INTEREST

Recovery Works providers must establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial gain for themselves or others, such as those with whom they have family, business, or other ties. Therefore, each institution receiving Recovery Works funds must have written policy guidelines on conflict of interest and avoidance thereof. These guidelines should reflect state and local laws and must cover financial interests, gifts, gratuities and favors, nepotism, and other areas such as political participation and bribery. These rules must also indicate how outside activities, relationships, and financial interests are reviewed and reported by the responsible and objective institution official(s).

INDEMNIFICATION

The Provider agrees to indemnify, defend, and hold harmless the State, its agents, officials, and employees from all claims and suits including court costs, attorney's fees, and other expenses caused by any act or omission of the Provider and/or its subcontractors, if any, in the performance of their Provider Agreement. The State shall not provide such indemnification to the Provider.

NON-SUPPLANTING CLAUSE

Recovery Works is a funding source of last resort. If services offered can be paid for by other state or federal programs/grants (e.g. Substance Abuse Prevention and Treatment Block Grant, Vocational Rehabilitation, Department of Child Services, etc.), private insurance, Medicaid, and/or Healthy Indiana Plan, Recovery Works cannot be billed for the services. An individual already receiving services through another program is ineligible for the **same** services through Recovery Works. It is not acceptable to remove a person from the alternate payer source, and transfer them to Recovery Works.

EXCLUSIONS

Recovery Works funds may not be used to:

- Pay for the purchase or construction of any building or structure to house any part of the program.
- Provide outpatient treatment services when the facility has not yet been acquired, sited, approved and met all requirements for human habitation and services provision.
- Pay for incentives to induce individuals to enter treatment.
- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- Pay for pharmacology for HIV antiretroviral therapy, sexually transmitted infections (STI), TB, and hepatitis B and C.
- Pay for services in a Recovery Residence that is not INARR certified and meeting all standards of Recovery Works.

SANCTIONS

Recovery Works reserves the right to implement sanctions for providers who do not follow the policies and procedures of any aspect of the Recovery Works Program.

Possible list of sanctions include:

- Suspension of new Recovery Works referrals
- Suspension from the Recovery Works Program for a period up to 3 years
- Monetary payment of services rendered
- Inability to access the Recovery Works systems

Recovery Works will attempt to provide as much notice as possible prior to sanctions being imposed. In some instances, this may not be possible, and Recovery Works may notify the provider as the sanction is being imposed. An example of possible inability to access systems:

It has come to Recovery Works staff attention that a provider has continued to bill for services for which they are not authorized to bill. The provider has previously been notified of issues, but continues to bill. In this instance, Recovery Works may suspend the provider's access to the billing system immediately, until a formal meeting is held, and an agreement on how to move forward is reached.

SUSPENSION AND TERMINATION

Recovery Works staff may, by written notice to the Agency and/or Provider, terminate the whole or any part of the Agency Agreement for any of the following reasons:

1. If the Agency/Provider fails to comply with any terms, conditions, requirements, or provisions of the Agency Agreement and/or Policy and Procedures Manual, Recovery

Works shall notify the Agency/Provider in writing of their failure to comply and immediate suspension. Should the Agency/Provider not remedy such failure within a period of time specified in writing by Recovery Works, the Agency Agreement may be terminated.

2. If the Agency or any of its officers, employees or agents commit participant abuse, neglect or exploitation, malpractice, fraud, embezzlement or other serious misuse of funds during the term of provider agreement, Recovery Works may terminate the Agency Agreement immediately upon written notice to the Agency.
3. Recovery Works may suspend or terminate the Agency Agreement in the case of financial limitations such as loss or expenditure of funds.
4. The Agency agrees that, the existence of a dispute notwithstanding, it will continue, without delay, to carry out all its responsibilities under the Agency Agreement that are not affected by the dispute.
5. Recovery Works or the Agency may terminate Agency Agreement without cause upon thirty (30) days written notice to the other party.
6. Recovery Works can suspend/terminate an Agency Agreement if negative action is taken by any State entity against an Agency/Provider.

If an agency is terminated, they may not apply to become a Recovery Works agency/provider for three (3) years.

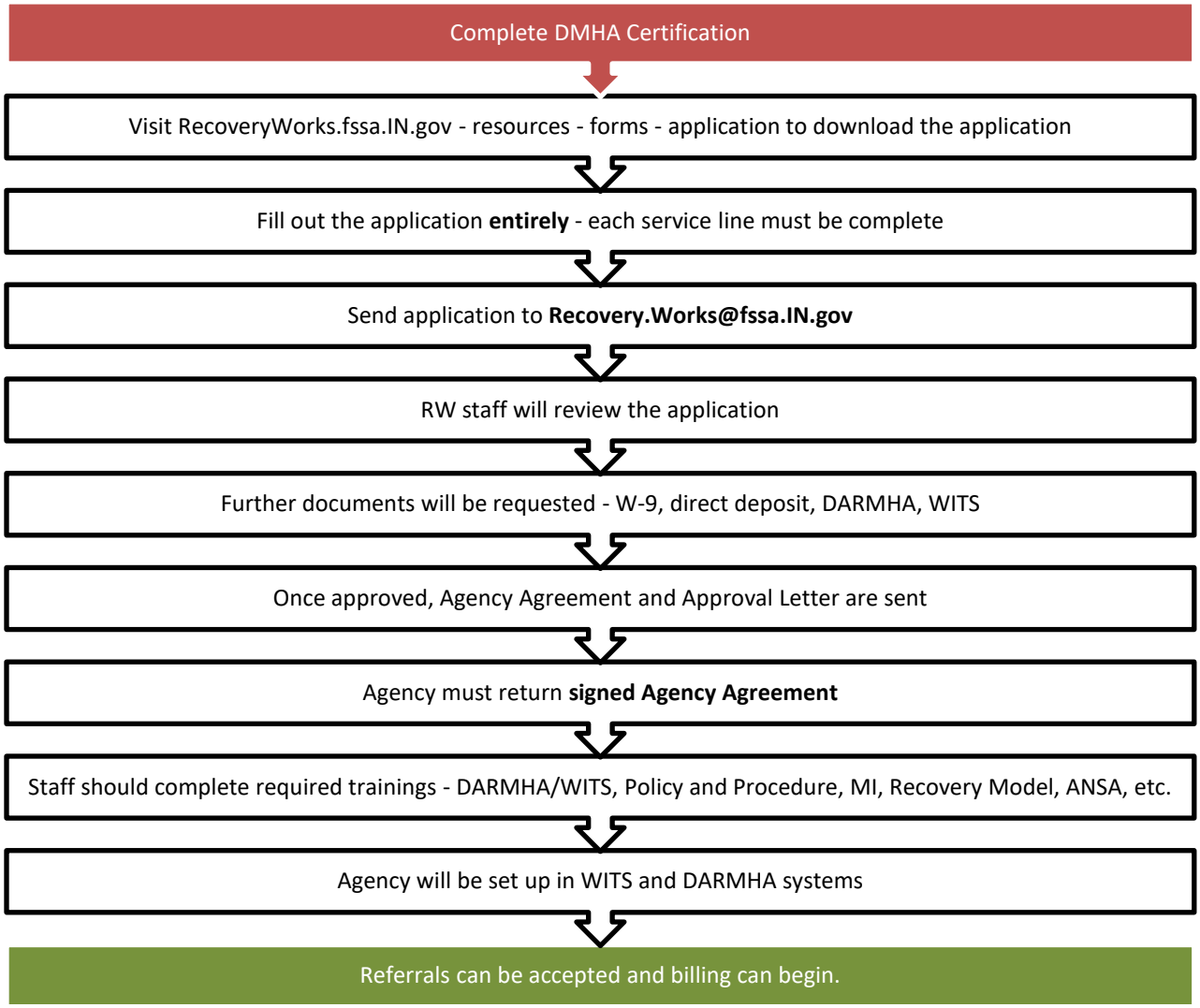
Designated Agencies and Providers

RECOVERY WORKS CERTIFICATION

All treatment providers must be a DMHA certified CMHC, ASO, ASR, PIP, or OTP agency before becoming an approved Recovery Works designated agency. All recovery residences must be certified through the Indiana Affiliation of Recovery Residences (INARR) prior to submitting a RW application. Organizations interested in providing treatment services must apply with the Indiana Division of Mental Health and Addiction. The certification process involves the completion of necessary forms and attending all required trainings. Successful certification will authorize agencies to obtain reimbursement for providing services to Recovery Works participants.

As of July 1, 2019, Recovery Works will not reimburse any providers who are not also currently enrolled as a Medicaid/HIP provider.

DIAGRAM 1: WHAT ARE THE STEPS TO BECOMING A DESIGNATED Recovery Works AGENCY?



QUALIFICATIONS FOR DESIGNATED SERVICE PROVIDERS (DSP)

After becoming a Recovery Works designated agency, individual providers within the agency can become designated service providers (DSP). In order to be an approved designated service provider, individuals will have basic educational and/or licensure requirements. Based on the Indiana Professional Licensing Agency (IPLA) standards and Indiana Code, providers must practice within the established scope of work for the provider's degree, licensure, and/or experience. Designated service providers for Recovery Works will be qualified within one of the following designations:

Designated Service Provider Qualifications

DSPs delivering service must meet appropriate federal, state, and local regulations for his/her respective disciplines. Specific provider qualifications, program standards, and exclusions are included in each service definition. Three predominant categories of providers may provide Recovery Works program services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Licensed Professional - A licensed professional is defined by any of the following provider types:

- Psychiatrist
- Physician
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *IC 25-23.6-10.5*

Qualified Behavioral Health Professional - A QBHP is defined by any of the following provider types:

- An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined previously; such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
    - Psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse (RN) in Indiana
    - Pastoral counseling from an accredited university
    - Rehabilitation counseling from an accredited university

- An individual who is under the supervision of a licensed professional, as defined previously, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
    - Social work from a university accredited by the Council on Social Work Education
    - Psychology from an accredited university
    - Mental health counseling from an accredited university
    - Marriage and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined previously
- An authorized health care professional (AHCP):
    - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *IC 25-27.5-5*
    - A nurse practitioner (NP) or a clinical nurse specialist (CNS), with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*

Other Behavioral Health Professional - An OBHP is defined by any of the following provider types:

- An individual with an associate degree or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards **set forth by the designated agency** and supervised by a licensed professional or QBHP, as defined previously
- A licensed addiction counselor (LAC), as defined under *IC 25-23.6-10.5,* supervised by a licensed professional or QBHP, as defined previously

*Information taken from Indiana Medicaid Manual and Indiana Professional Licensing Agency standards and codes. All agencies must have their own version of OBHP's in addition to the above Recovery Works definition.

PERSONNEL POLICIES

ORIENTATION

The Recovery Works designated agency shall provide an orientation that includes an explanation of mission or purpose statement for support services, job description or duties, review scope of work, overview of written policies and procedures, and code of ethics explained and signed by the employee. In regards to Recovery Works, providers are expected to provide all staff with information about the agency's participation in the Recovery Works program, including where calls or inquiries about Recovery Works should be directed. Additionally, agency staff should be informed about the Recovery Works referral process. This is to ensure that the best interests of the participant, including continuity of care, are maintained to the best of the provider's ability.

PERSONNEL MINIMUM REQUIREMENTS

The agency shall employ or recruit individuals with the necessary qualifications to effectively execute their position. Paid personnel who provide support services must attend any required credentialing training. All paid employees providing Recovery Works services must meet the minimum staff requirements as outlined in the Qualifications for Certification section.

PERSONNEL FILE

The purpose of this file is to show qualifications and experience of personnel. Personnel include all individuals that work with Recovery Works participants, regardless of whether they are hourly employees, salary employees, or contractors. Personnel files may be reviewed by Recovery Works administrative staff for verification that rendering staff meet the minimum qualifications. The file shall contain a minimum of the following items:

1. Job description or scope of work
2. Resume or list of volunteer or life experiences, including evidence of applicable training
3. License, certification, or related credentials (this includes updated copies if expired)
4. Proof of Completion of the following mandatory trainings:
    - Policies and Procedures Training for all staff supervising those involved in Recovery Works
    - DMHA Online: Recovery Model for all staff involved in Recovery Works
    - DMHA Online: Working with the Justice Involved for all staff involved in Recovery Works
    - Motivational Interviewing for all staff that have direct care responsibilities
    - Personal Safety or Non-violent Crisis Intervention training for all staff that have direct care responsibilities
    - CEUs for forensic, mental health, and/or Substance Use Disorder-related trainings each year

RECOVERY WORKS TRAINING POLICY

Recovery Works training requirements can be found on the RW website by navigating to resources – training. Appropriate Recovery Works designated providers must attend or have certification/proof of attendance in:

- **DARMHA/WITS Training**: Online PowerPoint or in-person session, must be viewed by those that will be performing billing responsibilities and/or entering data. The DARMHA/WITS user manual should also be printed and provided to each employee using the systems.
- **Online Policies and Procedures Training**: In-person session, must be viewed by

supervisors of Recovery Works staff prior to beginning program for agency

- **ANSA Training**: Online training, please review criteria on Schoox website, ALL staff that will be performing assessments must be ANSA certified prior to accepting Recovery Works referrals. Staff must recertify prior to certification expiration date to continue rendering services.
- **DMHA Online: Recovery Model**: Online webinar, must be viewed by all staff that are working directly with Recovery Works participants, must be viewed within 45 days of becoming a provider or employment
- **DMHA Online: Working with the Justice Involved**: Online webinar, must be viewed by all staff that are working directly with Recovery Works participants, must be viewed within 45 days of becoming a provider or employment
- **Motivational Interviewing**: In-person training, must be taken by all staff that are working directly with Recovery Works participants;
    - Exceptions: Licensed Professionals, and QBHPs who have received Motivational Interviewing supervision and who have attended a MINT (Motivational Interviewing Network of Trainers) training within the last three (3) years are eligible to view a webinar in order to verify competence, all others must take training as close to 90 days of becoming a provider or employment as possible. For those that have received MI supervision and training within the past three (3) years, you can view the webinar at http://bit.ly/motivationalinterviewingwebinar.
- **Personal Safety or Non-violent Crisis Intervention training**: In-person training, must be taken by all staff that are working directly with Recovery Works participants, must take training as close to 90 days of becoming a provider or employment as possible. *(Note: This should be offered in house and you should provide us with documentation of how you complete.)*

Once a provider has attended, they must keep their certification/attendance verification in their personnel file. A training checklist can be found on the RW website, which is sufficient documentation for the online webinars. It may also be reviewed by Recovery Works administrative staff for verification at any time.

Recovery Works requires that DSPs obtain CEUs for forensic, mental health, and/or Substance Use Disorder-related trainings each year. **Each year, DSPs, must designate 20% (4 hours) of their CEUs to forensic-related topics and 20% (4 hours) to mental health and/or Substance Use Disorder –related topic.** Certificates should also be kept in personnel files.

In addition to the trainings above, there are three types of access to the Web Infrastructure for Treatment Services (WITS) or Voucher Management System (VMS). They are as follows:

- **Rendering Staff:** These are the individuals at your agency who directly provide the

services to the participants and will be signing the contact logs. They will have accounts in WITS, but it will only show as rendering staff. They will not receive a login or password, but their names need to be in the system as rendering staff, so that the agency can bill appropriately with the proper rendering staff recorded.

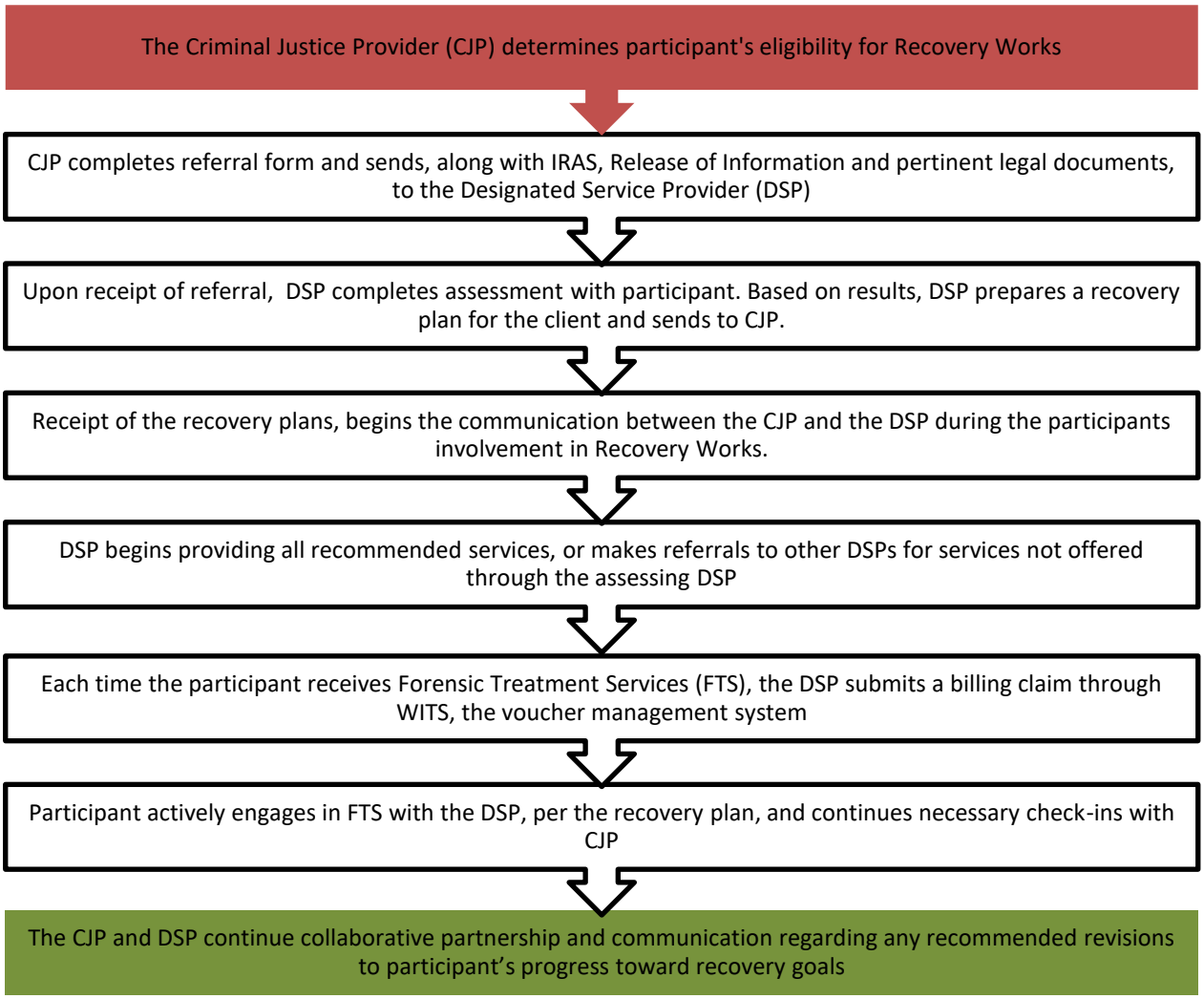
- **Data Entry:** These individuals will have access to the system to input participant data and billing encounters.
- **Release to Billing:** These individuals have all of the above access and are also permitted to release the information to the state government to be reimbursed for service(s) rendered. This is the highest level of access to the WITS system for a provider.

All personnel that have data entry or release to billing access, must successfully complete the Recovery Works Policies and Procedures Training and DARMHA/WITS Training. Training will provide detailed instruction on the WITS system. The DARMHA/WITS user manual should also be printed for each person with either of these access levels. Additional access of "agency reporting" is also available for those with data entry or release to billing levels who would like to view client overall expenditures. If a provider needs one on one training for clarification purposes, you may contact Recovery Works.

WHO IS A CJP?

A CJP is a Criminal Justice Provider. These are individuals that oversee or assist a client while they are in the Criminal Justice System. Some examples are a Probation Officer, Parole Officer, Community Corrections Officer, Judge, Court liaison, Public Defender, Prosecutor, Private Attorney, Parole Liaison, Jail staff. If you have any questions as to whether an entity/individual qualifies as a CJP, please reach out to Recovery Works.

SCOPE OF WORK



Both the Criminal Justice Provider (CJP) and the Designated Service Provider (DSP) are an integral component of Recovery Works. Employees whose duties do not include direct participant contact are not subject to the forgoing qualifications. Recovery Works vouchers will only pay for DSP's in support of participants' recovery activities as outlined in their plan of care.

DESIGNATED SERVICE PROVIDERS (DSP) WILL:

- DSP will accept referrals from Criminal Justice Provider (CJP) and contact participant within two (2) to five (5) business days.
- DSP will obtain participant consent and release of information in order for DSP and CJP to communicate about participant.
- DSP will perform a comprehensive bio-psycho-social assessment and administer the Adult

Needs and Strengths Assessment (ANSA) **within 10 calendar days** to help assist the participant in prioritizing services that will be most beneficial to the participant's recovery.

- Based on results of assessments, DSP will develop a treatment plan. The intention of this plan is to assist the participant in beginning to plan their recovery and understand recovery as a long-term, lifestyle change. This is to be reviewed every 90 days and updated as needed. If there is not a diagnosis of mental health and/or substance abuse, the participant does not qualify for Recovery Works services.
- DSP will provide services based on participant's Treatment Plan, which is expected to be individualized to the client's needs. Treatment plans should not be standardized based on an agency's specific treatment requirements.
- DSP will communicate and document all of the participant's progress with his/her CJP.
- DSP, or designated agency representative, will submit billing claims into the Web Infrastructure for Treatment Services (WITS).
- DSP will develop a method for tracking client expenditures to ensure the client does not exceed any of the three (3) funding buckets. It is the responsibility of the agency to ensure proper expenditure for each client. If questions exist regarding funding availability, please contact Recovery Works.
- If DSP is unable to provide services on the client's treatment plan, he/she will make a referral in WITS to another Recovery Works Designated agency and/or provider to provide the services.
- If DSP is unable to provide an assessment due to unavailability, or if client is unengaged, for longer than 30 days, a new referral from the CJP is necessary. (For individuals unengaged for less than 45 days, an email, fax or follow-up letter from the CJP will suffice in lieu of a new referral.
- Ensure that participants remain connected to the program through ongoing contact (phone and in person), motivation and support.
- Maintain an ongoing electronic and/or physical record of all contact with participants. This includes maintenance of a physical file containing participant demographic and contact information, signed Release of Information documents, and any other ancillary information relevant to the participant. Maintenance of the electronic record will require agencies to create participant profiles, authorize vouchers for all services, and claim payment for DSP activity. Recovery Works participant files are to be stored in compliance with the Health Information Portability and Accountability Act (HIPAA) and other applicable state and federal privacy provisions, including, but not limited to,42 CFR Part 2.

NEW PARTICIPANT PROCEDURE

1. The Criminal Justice Provider (CJP) will initially determine the participant's eligibility and need for Recovery Works**.**
2. Upon determination of eligibility, the CJP and participant will complete the Recovery Works referral form. The CJP will collect necessary collateral information such as: a completed IRAS, Release of Information, court documentation, arrest records, other pertinent legal information, assessments with participant, any information that would share with the DSP why the participant is being referred to Recovery Works. The CJP will send the referral form, and the collateral information to the Designated Service Provider (DSP).
3. Upon receipt of the Recovery Works Referral form from the CJP, **the DSP is expected to verify the client's eligibility** and **must** contact the participant within two (2) to five (5) business days, and set up an in-person appointment. Agencies may choose to provide "Open Access" appointments to their participants. If agencies choose this route, Recovery Works participants MUST be seen on the day they show up for an assessment. At the in-person appointment, the DSP will:
    - Perform a Comprehensive Mental Health and Substance Use Disorder assessment
    - Perform the Adult Needs and Strengths Assessments (ANSA)
    - Enter all participant information into DARMHA – demographic, diagnosis, NOMS, ANSA
4. After completion of the Comprehensive Mental Health and Substance Use Disorder assessment and ANSA, an individualized treatment plan is developed that addresses all areas of potential need. The intention of this plan is to assist the participant in beginning to plan their recovery and understand recovery as a long-term, lifestyle change. This is to be reviewed and updated at a minimum of every 90 days. The DSP will speak with the participant to determine which services will be most beneficial to the participant's recovery based on individual needs. These services will then be recorded on the treatment plan.

To allow the participant to receive the services on his/her treatment plan, the DSP will be responsible for creating vouchers and encounters within WITS for the participant based on his/her treatment plan. Vouchers and encounters must be created in WITS for each Recovery Works service the participant is to receive as reflected on the participant's treatment plan. Additionally, each encounter for Recovery Works services shall only contain one type of service, and should not be bundled (contain more than one type of service). The only exception is housing. Housing can be entered in 7 day increments, as long as all requirements are met for the participant in the house.

PARTICIPANT RECORD REQUIREMENTS

Participant clinical records maintained by Designated Service Providers (DSP) must contain a minimum of the following information (all entries shall be recorded in a timely manner):

1. Completed Recovery Works Referral Form – signed and dated
2. Pertinent Criminal Justice documents – must be sent from CJP

   ***DSP may not print MyCase or other online material as documentation. All documents must come from CJP. The documentation must show how the participant qualifies from a CJ standpoint.*
3. Participant's Comprehensive Mental Health and Substance Use Disorder assessment and ANSA results; results must indicate a DSM V or ICD 10 Substance Use Disorder, Mental Health Diagnosis, or Co-Occurring Diagnosis.

   ***If results do not indicate the above, then the participant is **not eligible** for Recovery Works. At no time is it acceptable to provide treatment for the individual who does not have a qualifying diagnosis at the direction of CJ providers.*
4. Completed Release of Information Form(s) – This includes a ROI to speak with the CJ provider
5. Supporting documentation for billing claims
6. Supporting documentation for insurance and/or progress towards gaining access to insurance – All progress towards gaining insurance must be documented to show the current state. If at any time the participant loses his/her insurance, they are no longer eligible for RW until they are reconnected and able to utilize insurance (this excludes losing insurance due to incarceration).

Although Recovery Works does not require that documentation be placed in a participants' clinical records in a specific order, agencies are asked to use a consistent procedure and order in the development and maintenance of participants' records. This will decrease agency staff confusion and make the compliance check process more efficient.

PROCEDURES

ASSESSMENTS

In order for a participant to be eligible to receive Recovery Works treatment services, they must receive a face-to-face comprehensive assessment that results in a Substance Use Disorder, Mental Health Disorder or Co-Occurring Disorder diagnosis designated by the DSM 5 (Diagnostic and Statistical Manual) or ICD 10 (International Statistical Classification of Diseases). **If participants do not have a diagnosis, they are not eligible to receive Recovery Works funded services.** In the instance that a participant does not have a diagnosis, we ask that the DSP inform the CJP that the participant is not eligible based on diagnosis criteria. A completed assessment that does not result in a DSM 5 or ICD 10 Substance Use Disorder, Mental Health Disorder or Co-Occurring Disorder diagnosis is not billable through Recovery Works.

If a Recovery Works Participant is already receiving services from a designated Recovery Works agency prior to receiving a referral, that same provider may choose to skip the initial comprehensive assessment and continue services. If you feel that the participant has had a significant change since the last comprehensive assessment, or it has been longer than 6 months, we ask that a new assessment be done. The new assessment can be claimed for under Recovery Works.

INSURANCE

The Recovery Works program is a payer of last resort. If a participant has any other payer source (i.e. private insurance, Medicaid, HIP 2.0, etc.) he/she must go to a provider that accepts his/her insurance coverage. For example, if Angie has insurance, and she chooses to go to a provider that is outside of her insurance network, Angie has to pay for those services out of pocket. Recovery Works cannot be used for the services Angie wishes to go to. The same goes for our Recovery Works Participants. If they choose to go to a provider that does not take their insurance, they must pay for those services. Therefore, if you do not accept a client's insurance, they must go somewhere that does.

Please consider the following scenarios:

1. **Participant has Medicaid, HIP 2.0, or other insurance coverage**: he/she will need to select a provider who accepts his/her coverage.
2. **Participant is eligible for Medicaid or HIP 2.0**: he/she will need to sign up for coverage. The provider receiving the referral shall connect the participant with a navigator or provide assistance to get the participant enrolled. Upon approval, the participant will need to receive services from a provider who accepts his/her coverage.
3. **Participant is "pending" coverage for Medicaid or HIP 2.0**: he/she will need to select a provider who accepts his/her pending coverage. The provider will bill the insurance for retro payment, and recovery works funds can be used to cover any claims for eligible services that are denied for the pending period. If the individual is denied coverage from Medicaid, HIP 2.0, or other insurer, a request can be made via JIRA to cover services.
4. **Participant is ineligible for insurance coverage through another payer source, or has been denied**: A JIRA request containing the denial form, plan of services, and reason of ineligiblity should be submitted to determine if services will be covered through Recovery Works. At no time should providers bill for services resulting from a denial without the prior approval of Recovery Works.

It is imperative that our participants are choosing providers accordingly, as preservation of funding for the individual is crucial to their recovery.

Recovery Works Designated Service Providers (DSP) have **ten (10) business days** from the date of the participant's intake to assist with completion of necessary applications to obtain insurance and/or third party payer source. **Within 30 days from intake**, all paperwork must be obtained and submitted (if not initially submitted with the original application). If a participant does not wish to gain access to insurance or does not follow through with the necessary requirements of obtaining/maintaining insurance, they are no longer

eligible for Recovery Works funding. **Documentation of these activities must be included in the participant's record and will be reviewed during audits**. If action is not taken to assist the client in gaining access, then they are ineligible for Recovery Works. If it is found that no actions were taken to assist the client in gaining insurance, the agency will be responsible for reimbursement of all services provided. All participants must have active insurance within 45 days of beginning treatment. If barriers exist to the individual obtaining insurance within 45 days, notification must be given to Recovery Works regarding said barriers, along with a JIRA request to continue billing Recovery Works. Case Management services can be billed to Recovery Works for activities related to helping the participant secure the necessary documentation. All activities must be documented in a progress note, and must meet all Recovery Works guidelines.

Assistance with completion of necessary applications includes, but is not limited to, any of the following:

- Connect participant with a Navigator, and follow up with participant and navigator to ensure application submission is completed within 30 days from intake
- Help participant obtain personal documents needed for application, presumptive eligibility, or private insurance
- Designating a staff employee to sit with the participant while the participant completes an application online for insurance or Medicaid

Recovery Works is the payer of last resort. Therefore, services available through insurance must be billed to insurance prior to requesting additional services through Recovery Works. If insurance companies deny services, a reason for denials must be forwarded to Recovery Works through JIRA when requesting services and/or approval for services within 60 days. Recovery Works will not pay for out of network insurance denials. Additionally, Recovery Works will not approve denials based on medical necessity, i.e. if the insurance company states it is not medically necessary, then it is not necessary for RW. The participant is expected to visit a network or facility that accepts their insurance. Please note, a hospital indemnity plan or medical plan only does not satisfy the requirement of insurance. The DSP is still expected to connect the participant to insurance for substance use and/or mental health needs. Case Management services may be utilized to help the participant gain the necessary documentation if necessary.

If a participant's insurance does not cover a service, Recovery Work may be utilized to cover the service. This should be done on a short term non-intensive basis. The participant's primary method of treatment should include the services offered by his/her insurance. If DSP's have questions or specific participant circumstances, please contact Recovery Works.

MEDICAID ACCEPTANCE:

Effective **July 1, 2019**, all Recovery Works treatment providers, who are DMHA certified to provide treatment services, must be enrolled as a Medicaid/HIP provider and credentialed with the Managed Care

Entities. Recovery Works will no longer accept any treatment provider who is not currently enrolled in Medicaid/HIP and credentialed with the Managed Care Entities.

Agencies are required to bill Medicaid/HIP for all services covered under Medicaid/HIP. The Recovery Works program is a payer of last resort. It is imperative that providers accept and bill insurance for clients to conserve a client's overall expenditure and funding.

REFERRAL POLICY

All participants must be referred to Recovery Works by a Criminal Justice Partner (CJP). **If a** participant **leaves treatment or there is a gap in services for more than 30 days, additional documentation from the CJP that sent the referral is required. Documentation can include an email, letter or a new referral for the participant. If a participant is absent for more than 90 days, only a new referral will suffice (the above documentation will not suffice).** The referral process **MUST** begin with a Criminal Justice Partner. It is unacceptable for Designated Service Providers (DSP) to send a referral to a CJP for a signature or to contact the CJP for a referral. If upon intake, it is determined that a participant may be eligible for the program and has a need for Recovery Works, DSPs must encourage participants to speak with their CJP regarding a referral. All services provided without a valid referral will be denied. If you are a CJP who receives a call from a provider to make a referral, please contact Recovery Works. The CJP must be directly involved with the participant whom they refer. If it is found the participant is not directly involved with the CJP, Recovery Works reserves the right to ask for reimbursement from the provider for services paid, as well as no longer allowing the CJP to refer to Recovery Works providers.

In addition to the referral, necessary collateral information must be shared with the DSP. This includes a court documentation, arrest records, legal information, assessments, and any other pertinent documents. The documentation must include how the participant qualifies for Recovery Works (i.e., felony information, current open case information etc.). It is the responsibility of the CJP and DSP to ensure eligibility. Referrals are only valid if all fields are filled out, and the participant meets full eligibility requirements. Incomplete referrals will be considered invalid.

EPISODES

All Episodes must be closed upon the participant leaving treatment. If the participant graduates from treatment, the open Episode is expected to be closed. If there is a gap in services of 30+ days, the open Episode should be closed, and the participant will need a new referral to restart treatment. In rare cases (with an approved PA), individuals may be involved for 12+ months, the individual's episode must be closed after 1 year in treatment, and a new referral must be received for the participant to continue treatment.

AGENCY DESIGNATION

Designated Service Providers are categorized as either treatment providers or housing providers.

Treatment Providers are:

- DMHA certified as a CMHC, ASO, ASR, PIP, or OTP agency – can include level IV recovery residences
- Responsible for the clinical comprehensive assessment, ANSA, diagnosis, and treatment plan
- Required to enter necessary information into DARMHA and WITS
- Able to build vouchers for their agency and housing providers
- Capable of making internal referrals within WITS to housing providers – allows housing providers to be paid directly

Housing Providers are:

- INARR certified as a level II, III, or IV recovery residence
- Able to accept participants prior to connection to treatment for an assessment
- Required to communicate with treatment providers and CJP regarding clients
- Must refer participants to a treatment provider within 7 days of intake and follow up on treatment
- May only claim for the daily housing rate as well as a daily per diem

BATTERERS INTERVENTION PROGRAM

Batterers Intervention Programming (BIP) and other similar programming is not a covered service under Recovery Works. In order to stay true to the program, part of the restitution of the model is that the batterer is responsible for the cost of their treatment. Therefore, Recovery Works will not cover the cost BIP or programming similar to BIP, including anger management and violence de-escalation. If you have a question about qualifying services, please contact Recovery Works for clarification. Recovery Works reserves the right to disallow any service deemed to be similar to BIP.

INSURANCE DENIALS AND MEDICAL NECESSITY

If an individual is released from jail, and the insurance company denies treatment due to lack of medical necessity, Recovery Works will consider the denial up to the number of days listed below. This policy is for insurance denials based on medical necessity due to incarceration only, and cannot be utilized for any other denial explanation. Coverage should be utilized to help stabilize the participant, as well as help the participant transition to a lower level of care. Providers will need to still send a denial and all pertinent documentation utilizing the JIRA system. All services provided will be billed as a bundle (all inclusive), and additional billing for services is prohibited. The maximum service allocation is:

Residential Level 3.5: Maximum of 3 days
Residential Level 3.1: Maximum of 5 days

All other insurance denials can be sent to Recovery Work via JIRA for consideration of payment. Please note, if you have any questions regarding denials, contact Recovery Works.

RECOVERY WORKS FORMS

RECOVERY WORKS DESIGNATED AGENCY AND PROVIDER APPLICATION

The Recovery Works Application is a form that allows the Recovery Works Administrative team to approve and designate agencies to provide Recovery Works services throughout the State of Indiana.

Once an application is received at the state office, the administrative team will review the application. If the application is incomplete, the provider will receive the application back to be corrected. The application will then be passed to the DMHA Certification Team where they will then approve all certifications and licensures of the agency and providers. All providers must be in good standing with all divisions under the Family and Social Services Administration. It is the agency's responsibility to report to DMHA any adverse sanctions, terminations, and arrests, which would affect the eligibility of the provider to provide services. A provider application must include documentation that previous sanction(s) have been remedied.

For Recovery Residences, it is required that all Recovery Residences are certified through the Indiana Affiliation of Recovery Residences (INARR). Only Level IV Recovery Residences are also required to be DMHA certified.

Once the Recovery Works administration team receives the application back from DMHA certification, the application will be approved or denied. Regardless of approval status, the agency will receive notification via email with their current status.

Recovery Works will request that approved agencies send other documents including W-9, direct deposit, DARMHA, and WITS forms. After completing the entire process, approved agencies will receive the Policies and Procedures Manual, a list of training requirements, a formal approval letter, and the Agency Agreement that will need to be signed and returned by the appropriate agency party.

Treatment Providers files will contain a minimum of:

- Recovery Works application
- Proof of clearances from DMHA certification, DOR, and DWD
- List of personnel/providers within agency
- W-9 and direct deposit paperwork
- DARMHA and WITS access forms
- Agency approval letter
- Signed agency agreement

SIDE ONE OF THE APPLICATION

AGENCY APPLICATION
State Form 55944 (R5 / 8-19)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

AGENCY INFORMATION	
Name of organization *(As Registered with Indiana Secretary of State)*	
Organization Employer Identification Number (EIN)	National Provider Identification Number (NPI)
Application Contact	E-mail address
Street address of agency location	City, state and ZIP code
Telephone number ( )	Fax number ( ) / Main E-mail address

MAILING ADDRESS OF ADMINISTRATION BILLING OFFICE	
Street address	City, state and ZIP code
Main telephone number ( ) / Fax number ( )	Website *(if available)*
County(ies) of service	
List types of insurance accepted by the agency (i.e. Medicaid, Health Indiana Plan (HIP), self-pay, etc.)	

SERVICES	***Mark with an X if your agency is providing the service; if your agency is not providing the service, please indicate a local agency that could render the service.***
Alcohol and Other Drug Screening	
Case Management	
Comprehensive Mental Health and Substance Use Disorder Assessment	

Information provided on this application, specifically phone number, email and insurance policies, will be uploaded to the provider list on the Recovery Works website.

Every service line must be filled out. If your agency provides a service, you will mark an "x". If your agency does not provide a service, you will write who you will partner with to provide the service.

SIDE TWO OF THE APPLICATION

PROVIDER INFORMATION		
PROVIDER NAME *(FIRST, LAST)*	**DEGREE AND/OR LICENSURE**	**Would you Qualify to be a: OBHP / QBHP**
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP

(If you have additional providers, please attach their information to the application in an Excel workbook.)

By signing below, your agency agrees that your providers will attend all mandatory Recovery Works trainings prior to providing services. Additionally, your agency will only claim for services marked with an "X" on page 1.

Signature	Date *(month, day, year)*
Printed name	
Title	

RECOVERY RESIDENCE APPLICATION:

RECOVERY RESIDENCE APPLICATION

State Form 56415 (R3 / 8-19)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

AGENCY INFORMATION		
Name of organization (*As Registered with Indiana Secretary of State*)		Organization Employer Identification Number (EIN)
Application Contact		E-mail address
Street address of agency location		City, state and ZIP code
Telephone number ( )	Fax number ( )	Main E-mail address

MAILING ADDRESS OF ADMINISTRATION BILLING OFFICE		
Street address		City, state and ZIP code
Main telephone number ( )	Fax number ( )	Website (*if available*)
County(ies) of service		
List types of insurance accepted by the agency (i.e. Medicaid, Health Indiana Plan (HIP), self-pay, etc.).		
Indiana Affiliation of Recovery Residences (INARR) certification level		

ADDRESS(ES) OF RECOVERY RESIDENCE(S) *(number and street, city, state, and ZIP code)*

SERVICES	*Mark with an X if your agency is providing the service.*
Recovery Residence – Room Only	
Recovery Residence – Room and Board	
Per Diem – Level II	
Per Diem – Level III	
Per Diem – Level IV	

PARTNERS – *Please list local treatment providers you will work with for clinical treatment.*	
Agency Name	Agency Contact

RECOVERY WORKS DESIGNATED AGENCY AGREEMENT

The Recovery Works Agency Agreement is an agreement between DMHA and the Recovery Works Designated Agency. This agreement operates similarly to a contract between the two agencies and can be terminated by either party with a 30-day written notice. Once an agency is approved to become a designated Recovery Works Agency, they will receive written notification, along with the agency agreement. The agency is asked to have the appropriate party sign the agreement, and return the agreement to the Recovery Works administration in a timely manner. Once the agreement is returned, your agency officially becomes a Designated Recovery Works Agency. At this point, you will be ready to attend a New Provider Training Session prior to billing.

Division of Mental Health and Addiction
402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-232-7909

Recovery Works – Designated Agency Agreement

This agreement is entered into by Family and Social Services Administration, Division of Mental Health and Addiction, Recovery Works Program (State) and --- (Agency), under the terms and conditions set forth below. This agreement authorizes the Agency to operate as a Recovery Works Provider. In consideration for this Agreement, the parties agree as follows:

1. Access to Records.
The Agency and its subcontractors, if any, shall maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Agreement. Agency shall make such records available at their respective offices at all reasonable times during this Agreement, and for three (3) years from the date of final payment under this Agreement, for inspection by the State or its authorized designees. Copies shall be furnished at no cost to the State if requested.

RECOVERY WORKS REFERRAL FORM

The Recovery Works Referral Form will be filled out by the Criminal Justice Provider (CJP) and faxed or emailed to the designated Recovery Works Agency. Once received, Recovery Works Providers will have two (2) to five (5) business days to accept the referral, contact the participant, and schedule an appointment with the participant. It is expected that the assessment is completed within 10 days from the date of referral acceptance.

All participants must be referred to Recovery Works by a Criminal Justice Partner (CJP). **If a client leaves treatment at a DSP for more than 30 days, a new referral is required.** The referral process MUST begin with a Criminal Justice Partner. It is unacceptable for Designated Service Providers (DSP) to send a referral to a CJP for a signature. If upon intake, it is determined that a participant may be eligible for the program and have a need for the program, DSPs must encourage participants to speak with their CJP in order for a referral to be made. Any and all services provided without a referral will be denied.

SECTION ONE: ELIGIBILITY

The eligibility section of the referral form will verify the four (4) eligibility criteria points. It will be the responsibility of the CJP to initially verify this criteria. As the provider, please re-verify with your participant and ensure documentation is kept in the client's file. Both the CJP and DSP are responsible for verifying eligibility. If the CJP makes a referral to a DSP, who provides and bills for services, then later finds out the client never qualified, the services rendered will be disallowed by the DSP and a reimbursement required.

To further clarify eligibility, the participant must have a **prior or current felony conviction** and currently be involved in the criminal justice system. If there are any questions as to if an individual qualifies, please reach out to the Recovery Works team. A few examples below:

1. Participant currently has a **felony charge** with no previous criminal history – the client is eligible for Recovery Works services ***until*** their charge is lowered to a misdemeanor.
2. Participant currently has a misdemeanor charge with a previous **felony conviction** – the client is eligible because of the previous felony conviction.
3. Participant currently has a misdemeanor charge with a previous **felony charge** – the client is <u>not</u> eligible because the individual was not convicted of a felony.
4. Participant previously has a felony conviction but does not currently have any criminal activity – client does not qualify because he/she is currently not involved.

Please verify the following eligibility requirements. Check all boxes that apply. If the participant does not meet all four (4) requirements he/she is NOT eligible for Recovery Works.

ELIGIBILITY REQUIREMENTS
☐ Is the participant a resident of Indiana?
☐ Is the participant at least eighteen (18) years old?
☐ Taxable income of the participant does not exceed 200% of the federal income poverty level. *(Taxable income includes participant, spouse, and dependents.)* (i.e. How much would the participant claim on taxes?) 2018 FPL = 1: $24,280; 2: $32,920; 3: $41,560; 4: $50,200; 5: $58,840; 6: $67,480; 7: $76,124; 8: $84,760
☐ Has the participant entered the criminal justice system with a felony charge or with a prior felony conviction?

I affirm that I have verified the above eligibility requirements to the best of my knowledge, information and belief.	
Referring Criminal Justice Provider Signature	Date *(month, day, year)*
Referring Criminal Justice Provider Name *(Printed)*	

SECTION TWO: PROVIDER REFERRAL

The Criminal Justice Provider will present the participant with a list of Designated Recovery Works Agencies. Criminal Justice providers must allow the participant a choice of providers from the full Recovery Works list, and cannot monopolize the list of providers (exception includes distinguishing a Recovery Residence from a Treatment Provider, but must use the total list of Treatment provides or Recovery Residence Providers from the specific area). From that list of agencies, together the participant and the CJP will choose the most appropriate agency for the participant and make the referral based on that. Once the participant has made his/her choice, the CJP will continue to fill out the remainder of the form.

***Please note: all DSPs are required to bill insurance as the primary payer source. See pages 30-31 for further clarification.*

I _____, understand I am being referred to Recovery Works. I will inform my
(Enter Name of Participant.)
Criminal Justice Provider (CJP) if I have been involved with Recovery Works previously in order to help plan my referral appropriately. I understand there are a number of providers qualified to provide the many services I may require during my participation in Recovery Works. I also understand I may interact with multiple providers throughout my participation in Recovery Works. I understand the agency below will help me get started.

Name of Recovery Works Agency *(Agencies can be found at www.RecoveryWorks.fssa.IN.gov.)*	
Telephone Number ( )	Information Sent to Recovery Works Agency? ☐ Yes ☐ No

SECTION THREE: PARTICIPANT INFORMATION

Once the participant has chosen the Recovery Works Agency, together with their CJP, they will continue to fill out the referral form. The CJP will fill in their contact information and the participant will fill in their contact information.

I understand if I find the above agency does not meet my needs, I will speak with my Criminal Justice Provider (CJP) and together we will find a new agency and/or provider that does meet my needs. I also understand the above agency may not be willing or have the ability to provide services to me at this time, in which case my CJP and I will need to select a different provider.

I authorize the referral agency (CJP) to release my information to help the Recovery Works agency contact and serve me:			
Name of referring CJP agency		Referring Agent E-mail	
Name of referral agent		Telephone Number ( )	
I understand that the Recovery Works Agency/Provider will need to contact me. I authorize them to contact me by contacting me at the following:			
Address *(number and street, city, state, and ZIP code)*			
Date of birth *(month, day, year)*	Home telephone number ( )	Cell telephone number ( )	Work telephone number ( )
Signature of Client		Date *(month, day, year)*	DOC identification number *(optional)*
If client is currently incarcerated, please share the date of release if accessing services within thirty (30) to ninety (90) days pre-release *(month, day, year). Services can be provided at ninety (90) days pre-release in our pilot counties only. (Leave blank if not applicable.)*			
Comments:			

Once the entire form has been filled out, the CJP **is required** to email or fax the form, along with supporting documentation, to the chosen Designated Recovery Works Agency. Documentation that the referral was received must be kept in the participant file. Upon receipt, the DSP must also verify eligibility of the participant.

RECOVERY WORKS PRIOR AUTHORIZATION FORM

The Prior Authorization form will be utilized by Recovery Works designated providers that wish to provide services that require a Prior Authorization, or to request a service cap increase for extenuating circumstances. The provider will fill out the online, PDF fill-in form in its ENTIRETY and email the document to Recovery.Works@fssa.in.gov with the participants WITS ID # ONLY, no personal health information. For more information on how to fill out PAs properly, please review our webinar which can be found at www.RecoveryWorks.fssa.in.gov. Clinicians may bill up to a maximum of 30 minutes (2 units) of case management when completing Prior Authorizations. When completing a Prior Authorization. Please note, answering all the questions completely is required and not an optional part of the process. It will expedite the approval process and reduce the likelihood of a denial if all the directions are followed. Should you need to select multiple services for a prior authorization, you will need to complete individual prior authorization forms for each service that you are requesting. Recovery Works will not provide a denial for a PA for the sole purpose of requesting an alternate funding stream. All aspects of the PA process must be followed prior to Recovery Works denying the PA.

PRIOR AUTHORIZATION
State Form 55941 (R4 / 5-17)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

Please e-mail completed form to Recovery.Works@fssa.IN.gov.

Name of designated agency	Date *(month, day, year)*
Name of designated provider	
DARMHA identification number	Internal agency identification number
Type of prior authorization ☐ Prior Authorization Service ☐ Other	

Prior Authorization Services:

- ☐ Medication Assisted Treatment (OTP Bundle) Monthly PA
- ☐ Medically Monitored Inpatient Detoxification
- ☐ Thirty (30) to Ninety (90) Days Pre-Release Services
- ☐ Clinically Managed High-Intensity Residential Services
- ☐ Clinically Managed Low-Intensity Residential Services

NARRATIVE

Please provide a narrative about this participant. Ensure ALL questions are addressed.

1. What specific circumstances make the requested service the most appropriate option for this participant? *(Answer should be individualized.)*
2. What services and supports has the participant already utilized? Included what did and did not work well and why. *(If participant has had previous attempts with the service currently being requested, explain what will be different this time.)*
3. How does this service fit into the participant's overall individualized treatment plan and goals?
4. What other less intensive / restrictive services were considered? Why do you believe those services are not appropriate at this time?

Voucher Management System/ Web Infrastructure for Treatment Services

WITS WEBSITE:

Web Infrastructure for Treatment Services (WITS) is the electronic voucher management system where Designated Providers will go to access participant information and billing. WITS also contains a section for announcements. This section will hold announcements as posted by Recovery Works administrative staff regarding training, upcoming events, changes, WITS outages, etc. The announcements on WITS will typically be dually posted on Recovery Works public website; however, this will not always be the case. The WITS site may be accessed via the Recovery Work website.

Voucher Management

The initial Recovery Works Designated Service Provider (DSP) will determine voucher availability for services. No other Provider can duplicate or supersede this function. Other Recovery Works Providers will only be paid for Recovery Works services provided to participants with an active and current Recovery Works voucher at the time the service is provided and with an active MOU with the initial DSP.

Voucher Reimbursement

Providers agree to accept reimbursement for services at the rate specified in the latest version of the Recovery Works Rate Sheet as updated from time to time by DMHA and posted on the Recovery Works website, www.RecoveryWorks.fssa.IN.gov . Providers should not ask participants to make additional payments for the portion of their care that is paid for by Recovery Works. When billing for services, providers have two options: they may bill daily or weekly. When billing weekly, providers MUST list out EACH day of service in the encounter notes. Additionally, in order to claim for a service, the service must have already been rendered. You may not bill for anticipated future services.

Vouchers must be built for 30 calendar days or less, and must start within 10 calendar days of when a DSP begins serving a participant. Encounters must be released within 10 business days of when a voucher ends.

Agencies are not allowed to contact Recovery Works to request an extension for billing unless it meets the following circumstances:

- In the case of insurance denials, in which the agency will need to provide a copy of the denial with a valid reason for denial, as determined by the Recovery Works team;
- In the case of login issues – if Recovery Works does not reset logins promptly, which results in providers being unable to complete billing, a late billing phrase may be provided.

WITS Access

To add or remove agency personnel from the WITS system, or change their WITS access level, the agency staff member with oversight of Recovery Works service provision must submit a ticket to JIRA with the WITS Access Spreadsheet attached. When removing access, the individual's account will be locked. It is required that agencies send the Recovery Works team an updated WITS Access Spreadsheet whenever additions or removals need to be completed. This includes additions of new rendering providers. All personnel of the DSP who administer services directly to RW clients must be entered into WITS as rendering staff. See page 24 for more detail. Accounts that are inactive for 180 days or more will be automatically locked.

JIRA Access

To request assistance for WITS related tasks, such as voucher adjustments or account resets, a ticket must be submitted to JIRA. Users can access JIRA at https://dmha.fssa.in.gov/helpdesk/?div=dmha. Once on the website, enter your email and click the "create ticket" button. Enter all required fields. For the related application section, please choose WITS – Recovery Works (if it automatically does not choose that for you). In the summary box, please enter what you would normally put as the subject line of an email. For the description, you can enter the body of the email, which would include what you are requesting (add units, reject encounter, WITS access, insurance denials etc.). Please remember to provide all information. If all information is not present, the ticket will be closed and you will be asked to complete a new ticket with the requested information.

Allow up to 48 hours for a response to each ticket. Only submit one ticket per request.

Recovery Works Billing Cycle

The Recovery Works adjudication process begins automatically within WITS on Friday afternoon at 12:00pm. On Saturday morning, all claims that were accepted, move forward to be processed and paid. Any claims that the system had questions about move to a pending status. Those claims with a pending status are reviewed by Recovery Works staff by 4:00pm on Wednesday the following week. If the claims are approved, they move on to be processed for payment.

Once a claim is approved and is processed for payment, it is sent to the Auditor's Office. We send payments to Auditor's Office every Thursday afternoon. Once the Auditor's Office receives the payments, they have a billing cycle of 35 days. Therefore, you can expect payment approximately 35 days after the posted date in WITS.

Example 1:

Encounter released Tuesday, November 27.

Payment batched in WITS Friday, December 2.

Payment approved in WITS Saturday, December 3.

Payment sent to auditor's office Thursday, December 8.

Agency receives payment January 26.

PUSHING TO WITS

Every Recovery Works participant needs to be pushed from DARMHA into WITS, even if the provider does not foresee them using Recovery Works funding. The only way for Recovery Works staff to count enrollments is through WITS. This is especially crucial if the participant is a Medicaid participant, as this is the only way that Recovery Works will know how to count that individual as enrolled for the program and to assist our agencies with their Medicaid Match.

CHOOSING A REFERRAL SOURCE

When creating an episode for a participant, it will ask the provider to indicate the referral source. It automatically fills in the box with "Criminal Justice Provider", however please click on the drop down box, where it will give more specific referral sources to choose from. Please use the more specific option in the drop down box, instead of leaving it as "Criminal Justice Provider." If the referral source used is not indicated in that drop down box, please let Recovery Works staff know by emailing us at Recovery.Works@fssa.IN.gov.

Recovery Works Services

FUNDING CATEGORIES

Recovery Works recognizes a need for flexibility and creativity in order to administer individualized services based on treatment planning. As such, we have changed the way we allocate funding for services. Please remember, these are maximum allocations, and DSP's are expected to utilize only the services that are necessary for the participant's recovery and included in the participant's treatment plan. Funding allocations are broken down into 3 specific categories:

1. **Re-Entry Funding**
2. **Community Funding**
3. **Recovery Residence Funding**

RE-ENTRY SERVICES – $1500 LIFETIME ALLOCATION

Re-Entry services are intended for individuals to use while in a correctional facility prior to being released into the community. This includes individuals residing in jails and/or Work Release facilities. DSP's should seek to provide only the services the participant needs to help ensure transition back into society. We have allotted a funding stream for re-entry services to any agency that offers this service

DSP's must:

- Verify full eligibility and need for Recovery Works
- Aim for as close to release as possible
- Utilize the services included on the Re-Entry Rate Sheet only

Please note, all work release facilities must apply with Medicaid to determine their particular level for Freedom of Movement. If a work release facility opts not to apply for their designation, participants within that facility are not eligible for Recovery Works until they are released from the facility.

Work Release facilities must submit a copy of the facility designation form to Recovery.Works@fssa.IN.gov. The participant must receive and participate in services based on the individualized treatment plan only.

Clinically Managed Residential Services (ASAM 3.1 and 3.5, and Recovery Residence) are excluded from Re-Entry Funding.

All jail "pilot" programs in Recovery Works (jail pilot, work release pilot etc.) ended as of October 1, 2019.

COMMUNITY FUNDING - $2500 MAXIMUM ALLOCATION

Community services are intended for individuals still involved with the criminal justice system, but no

longer incarcerated (work release, jail, prison etc.). DMHA Certified Treatment Providers are the only agencies able to utilize this service. Recovery Residences (excluding Level IV) must refer to section below regarding services for which they can utilize.

DSP's must:

- Verify full eligibility and need for Recovery Works
- Ensure the individual is living within the community and not incarcerated.
- Connect the individual to insurance within 10 business days
- Utilize the services included on the Community Rate Sheet only
- Keep track of participant spending from beginning to end
- Follow all other Recovery Works treatment policies and procedures.

The above funding is intended for gap services, and should be utilized as the funding of last resort. When the individual obtains insurance, the participant should immediately begin utilizing said insurance for services. Rehabilitative services (Skills Training, Case Management etc.) can be billed to Recovery Works while utilizing insurance services, however this should not be an intensive method of service or be the participant's primary method of service.

Clinically Managed Residential Services (ASAM 3.1 and 3.5, and Recovery Residence) are excluded from Re-Entry Funding.

RECOVERY RESIDENCE - $4000 MAXIMUM ALLOCATION

All Recovery Works (RW) providers desiring to offer housing assistance billed as Recovery Residence must have a designated Recovery Residence (RR) that is certified through the Indiana Affiliation of Recovery Residences (INARR). The RR must complete their certification with INARR prior to applying for RW. INARR will designate a level to each RR based on standards set forth by the National Affiliation of Recovery Residences (NARR). **RRs designated as a level IV facility must also become certified by the Division of Mental Health and Addiction (DMHA) as a treatment provider to participate in RW.**

It is the responsibility of the RR to maintain all current certification fees and standards of INARR in order to bill RW. If a RR is suspended from INARR, RW has the right to suspend billing and acceptance of referrals for the RR housing assistance services.

Policy:

All RRs, regardless of level, must obtain a current and complete RW referral from a criminal justice provider (CJP). Individuals seeking housing in an INARR certified Recovery Residences are no longer required to complete an assessment prior to obtaining housing. To ensure the participant receives the treatment necessary to maintain recovery, Recovery Residences have 7 business days to refer to the participant to a treatment provider for an assessment, and must keep documentation of the participant being referred (see 7 day policy below).

Level I:

Recovery Works does not reimburse for any housing assistance or services provided in a Level I

recovery residence. This decision is based on the understanding that by the time an individual is titrated down to a level I home, they are able to pay the full amount themselves.

Levels II-III:

For levels II-III, the RR only bills for Recovery Residence Room & Board or Recovery Residence Room Only and per diem in WITS. The RR must determine which service they provide based on the service definition outlined on pages 78-79.

At intake, levels II-III are not required to complete a comprehensive assessment but must comply with the seven (7) day referral to treatment policy outlined in the next section.

If the RR desires to <u>bill</u> for any treatment services (AOD screens, case management, skills training, etc.), they must have a separate facility outside of the home that is DMHA certified and able to accept/bill Medicaid and other insurances.

Level IVs:

All level IV RRs are required to be certified by DMHA and accept/bill Medicaid as a treatment provider. Level IVs are required to follow all insurance guidelines and policies that other treatment providers follow, as outlined in the policy and procedure manual. If necessary, level IVs may bill for all services in WITS that they are qualified to provide, as long as there is adherence to the insurance policies and procedures.

At intake, a level IV RR must complete a comprehensive assessment for the client to develop a treatment plan. It is the responsibility of the house to create a plan for how the client will receive treatment services once they titrate down to a lower level home.

Per Diem:

To offset the cost of daily assistance to residents, including but not limited to, recovery meetings, orientation, training, and other services, RRs will be able to claim for a per diem rate as determined by the State, which is subject to change at any time.

Based on research and data collected from the RRs, DMHA has set the current per diems for RRs based on level:

- Level I: not covered under RW
- Level II: $6 per day per client
- Level III: $7 per day per client
- Level IV: $7 per day per client

<u>Service Cap</u>

Each RW participant will have a lifetime total of $4,000 set aside for their recovery residence necessity. These funds are reserved in a separate bucket in WITS for each participant, meaning each individual will have these funds reserved for housing. Shall an individual wish to use these funds for treatment services, the treatment provider may submit a prior authorization (PA) to have funds transferred to the treatment bucket.

The $4,000 is used for days of stay, as well as the per diem rate. The number of days per client will vary depending on whether they are receiving room only or room and board as well as the level in which the individual resides.

For example: If the individual is staying at a level III recovery residence, receiving room and board, that will allow 142 days of housing assistance, including the daily per diem. See Recovery Residence rate sheet for more clarification.

Billing

Recovery Works requires recovery residences to titrate participants down from Recovery Works funds and allow the participant to develop his/her own payment plan for housing. It is expected that housing staff have a conversation with the participant within seven (7) days of move-in regarding the titration plan. The Recovery Residence is expected to share the housing/titration plan with all clinical or treatment providers involved with the participant. An example of this is below:

Recovery Works will pay for 3 full months. On the 4th month, RW will pay for 3 weeks, and the participant will pay for 1 week. On month 5, RW will pay for 2 weeks, and the participant will pay for 2, etc.

In WITS, Recovery Residence is billed as one service – Recovery Residence RW. To determine the dollars/units to bill, each residence has the option of 2 main service allocations:

Room Only - $15/per day/per person

Room and Board - $20/per day/per person

Recovery Residences will add the appropriate per diem dollars/units to the Recovery Residence RW service when billing. Levels II & III cannot utilize community funding for services. Recovery Residence Level IV may utilize Community Funding for gap funding when necessary, however for individuals residing in the Recovery Residence, rehabilitative services (Skills Training, Case Management, Peer Recovery) are included in the per diem, therefore, prohibited from being billed separate.

7-Day Referral to Treatment Provider

All RRs, regardless of level, must obtain a current and complete RW referral and CJ documentation from a criminal justice provider (CJP). Individuals seeking housing in an INARR certified Recovery Residence are no longer required to complete an assessment prior to obtaining housing. To ensure the individual receives the treatment necessary to maintain recovery, Recovery Residences have seven (7) business days to refer to the participant to a treatment provider for an assessment, and must keep documentation of the participant being referred. Documentation must include:

- Date the participant was referred to the treatment provider, and the date of the participant's appointment.
- Daily case notes and/or progress notes regarding the participants daily activities
- Documentation of ongoing follow-up communication with the treatment provider. Documentation must exist a minimum of every 30 days.
- Any Pertinent information regarding the participant's treatment.

Recovery Residence Additional Guidelines:

- Recovery Works cannot be billed for "home passes" where the individual is not spending the

night in the Recovery Residence

- Recovery Residences cannot bill the participant for additional services in conjunction with Recovery Works. This includes deposits, administrative fees etc. Recovery Residences agree to only bill the participant for Room Only Or Room & Board, the Per Diem and clinical services (Level IV only) as required by the participant's treatment plan. The only exception to this is the last month of the participant's stay, when the participant is titrating down from Recovery Works services.
- Participants who utilize Recovery Works are involved with the program due to having a need for the service, and inability to afford the cost. Recovery Residences may not charge participants "up front" while awaiting Recovery Works reimbursement.
- Participants may not be charged an additional fee for administering medications. For example, *John is taking 3 medications a day. Upon entering the RR, John's medications are secured in a locked location, and administered to him daily at a cost of $3 per day.* These types of charges are prohibited. If you have any questions regarding additional charges, please contact Recovery Works.

PLEASE NOTE: RESIDENTIAL SERVICES ARE NOT INCLUDED IN THE ABOVE ALLOCATIONS. RESIDENTIAL SERVICE LIMITS ARE IN ADDITION TO THE ABOVE ALLOCATIONS:

Clinically Managed High Intensity ASAM 3.5 – $361.50/day (maximum 15 days)

Clinically Managed Low Intensity ASAM 3.1 - $126.46/day (maximum 21 days)

All Clinically Managed services require a PA for services. DSPs are still expected to ensure the individual is connected and utilizing insurance. If insurance is utilized, and Recovery Works has paid in the interim, DSPs are responsible for ensuring a refund is sent to Recovery Works. If insurance approves a set number of days, the DSP will need to work with the insurance company to obtain more days if necessary. For extenuating circumstances, Recovery Works may be able to assist with additional days.

SERVICE DEFINITIONS AND REIMBURSEMENT RATES

ONLY SERVICES DEFINED IN THIS MANUAL ARE BILLABLE TO RW. ANY DISCREPENCIES NEED WRITTEN APPROVAL FROM THE RW TEAM. RW IS A PAYER OF LAST RESORT. NO ADDITIONAL FEES MAY BE CHARGED TO RW PARTICIPANTS FOR SERVICES LISTED BELOW.

ALL SERVICES ARE SUBJECT TO CHANGE. PLEASE REFER TO THE RATE SHEET APPENDIX TO REVIEW YOUR SPECIFIC RATE SHEET BASED ON THE BUCKET YOU ARE BILLING FROM. CHECK THE WEBSITE REGULARLY FOR UPDATES. BULK BILLING FOR SERVICES IS NOT ACCEPTABLE EXCEPT FOR RECOVERY RESIDENCES.

ANSA Redetermination - $77.72/unit (unit = 1 Face to Face Reassessment)

The Adult Needs and Strengths Assessment must be completed at intake and every six (6) months. The redetermination requires face-to-face contact with the participant and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which results in a completed redetermination. A DSP that is NOT receiving reimbursement through MRO or another payer source may claim one (1) Recovery Works voucher for each ANSA done at the six (6) month follow-up for the participant. A DSP may not claim for the intake ANSA, as it is included in the initial assessment package.

Who may claim for this service: Licensed Professionals, Qualified Behavioral Health Providers, and Other Behavioral Health Providers who hold an active ANSA certification through the Praed Foundation.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date and time of assessment
- Rendering Staff performing assessment
- And a completed actual assessment

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Participants must have an ANSA completed every six (6) months. Reminder: This service should only be billed to Recovery Works when no other funding is available.

AOD (Alcohol and Other Drug) Screening – $18.05/unit (unit = 1 screening)

This service should only be utilized in cases where AOD screening is clinically indicated as a means of removing barriers to recovery and/or triggers for relapse. At no time can AOD screening be billed to Recovery Works on behalf of the CJP. This service should only be billed to Recovery Works when no other funding is available.

Organizations providing AOD Screenings are expected to provide collection and analysis of appropriate

samples for the multi-substance drug testing. All tests must be at least a six panel drug tests administered with or without an accompanying alcohol breath or blood test. In addition to the six panel standard drug test, the participant must be tested for any substance they reported using at the time of intake. This means that the test will test for at least six classes of drugs commonly abused in the organization's area of service, as well as any substance being used by the participant at intake. EtG tests for alcohol may also be billed under this category, only when it is accompanying at least a six panel test for other drugs of abuse in the provider's service area. Organizations providing this service must have a policy in place that addresses and assures specimen validity by providing observed sample collection and maintains the chain of custody of the sample from collection to testing. Said policy and protocol must be established to be as minimally invasive as possible while meeting the above measures of accuracy.

The provider shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transferring and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody. For those employing urine tests, diluted results must be reported on the result form. Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

Who may claim for this service: Organizations meeting the standards above; must have current documentation of the administering provider's training by an outside AOD collection provider in the process and procedures of administration of the AOD screenings. Recovery Residence participants with less than three (3) years of treatment may not administer AOD screens.

Exclusions: AOD screening that is not clinically indicated to address needs or barriers identified on the participant's individual recovery plan.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date and time of sample collection
- Specific substances or classes of substances for which testing was performed
- Results of test
- Reason/type of test (Random, Scheduled, Suspicion of use)
- Location/type of test (On site/Instant test or Laboratory test)
- Rendering staff performing screen

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of the funds paid for the services and federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Participants may request that AOD screening vouchers be authorized to providers that have a random or cause based drug testing policy in case the participant is selected for a test. All tests should test for a multitude of chemicals, not less than seven, and not only the drugs of choice of the individual participant. If questions exist, it is the responsibility of the DSP to contact Recovery Works prior to billing.

Case Management - $14.53/unit (unit = 1/4 hour)

Case Management consists of services that help participants gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Case Management does not include direct delivery of medical, clinical, or other direct services. Case Management is on behalf of the participant, not to the participant, and is management of the case, not the participant. Case Management must provide direct assistance in gaining access to needed medical, social, educational, and other services. Case Management includes referrals to services and activities or contacts necessary for continuity of care.

Case Management may include:

- *Needs Assessment*: Focusing on needs identification of the participant to determine the need for any medical, educational, social, or other services. This cannot be completed each session, and should be conducted when necessary. Specific assessment activities may include:
    - Taking participant history
    - Identifying the needs of the participant
    - Completing the related documentation
    - Gathering information from other sources, such as family members or medical providers
- *Referral/Linkage*: Activities that help link the participant with medical, social, and educational providers, and/or other programs and services that are capable of providing needed rehabilitative services.
- *Monitoring/Follow-up*: Activities and contacts necessary to ensure continuity of care of the participant. The activities and contacts may be with the following:
    - Participant
    - Family members
    - Nonprofessional caregivers
    - Providers
    - Criminal Justice Providers
    - Other entities

  Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with the participant's recovery plan, the adequacy of the services in the treatment plan, and changes in the needs or status of the participant. However, monitoring must not include simply talking to the individual, but must include action on the part of the case manager.
- *Evaluation*: The provider must periodically reevaluate the participant's progress toward achieving the participant's goals. Based on the provider's review, a determination would be made whether changes should be made. Time devoted to formal supervision of the case between provider and licensed supervisor are included activities and should be documented accordingly. The supervision must be documented appropriately and billed under one provider only.
- Clinicians may bill up to a maximum of 30 minutes (2 units) of case management when completing Prior Authorizations. Please note, if the PA does not take 30 minutes to complete, you may not bill for both units, you will need to bill for the time it took to complete up to 30 minutes. When completing a Prior Authorization please note that answering all the questions completely is required and not an optional part of the process. It will expedite the approval process and reduce the likelihood of a denial if all the directions are followed. Should you need to select multiple services for a prior authorization, you will need to complete individual prior authorization forms for each service that you are requesting.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other

Behavioral Health Providers

Exclusions: The actual or direct provision of medical services or treatment is excluded. Examples include, but are not limited to:

- Training in daily living skills
- Training in work skills and social skills
- Grooming and other personal services
- Training in housekeeping, laundry, or cooking
- Transportation services
- Individual, group, or family therapy services
- Crisis intervention services
- Informal or brief interactions discussing client case
- Services that go beyond assisting the participant in gaining access to needed services. Examples include, but are not limited to:
    - Paying bills and/or balancing the recipient's checkbook
    - Traveling to and from appointments with recipients
    - Court-ordered reports
    - Assistance completing Medicaid application or redetermination documentation
- Meeting the participant for "talking session" as a case manager with the exception of the initial and continuity of care meetings.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff name

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Clinical Managed High-Intensity Residential Services - $361.65/unit (unit = 1 day); requires Prior Authorization – covers up to 15 days

Participants shall have a diagnosis of Substance Use Disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders current edition. This service is equivalent to the American Society of Addiction Medicine (ASAM) Level 3.5. **Clinical Managed High-Intensity Residential Services**

programs offer room, board, and interpersonal support to intoxicated individuals and individuals in substance use withdrawal.
All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care. This service is delivered under a defined set of physician-approved policies and procedures or clinical protocols.

Clinically Managed High-Intensity Residential Services is restrictive on the participant and involves medications and/or close, regular monitoring, such as Medically Monitored Inpatient Detoxification. Participants using substances other than those outlined for medical detoxification are typically put in to this modality of treatment to be observed and monitored for stability before entering into a traditional residential treatment program. This program is monitored and supervised by a Medical Director.

Minimum service requirements:

- Length of stay in clinically managed high-intensity residential services shall be determined utilizing the American Society of Addiction Medicine (ASAM) level of care criteria and requires prior approval of DMHA.
- Clinically managed high-intensity residential services shall have separate living areas for women and men. Eligible participants shall have significant impairment in physiological, social, occupational, and/or psychological functioning due to substance use. Participants may have a co-occurring disorder, defined as concurrent diagnosis of mental illness, and shall receive treatment for substance use and co-occurring disorders concurrently.
- **Treatment services shall be based on individual need and diagnosis**. Criminal Justice Partners cannot make a determination of treatment, however they can refer an individual to receive an assessment to determine treatment. Treatment services shall support participant self-sufficiency, decision making, empowerment, and disease self-management principles. Services include 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal.
- All services shall utilize evidence-based practices (EBP) and gender specific care. Evidence based practice is defined as programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results; show the greatest levels of effectiveness and have been replicated in different settings with different populations over time; and can include but are not limited to "treatment manuals." Evidence based practices for substance abuse is supported by the Substance Abuse and Mental Health Administration (SAMHSA): National Registry of Evidence-based Programs and Practices (NREPP).
- Provider shall have individualized, holistic, and comprehensive recovery/discharge plans for all participants utilizing community resources, recovery support services, and clinical interventions in the community of the participants' primary residence.
- All clinically managed high-intensity residential services shall be designed to practice and utilize recovery oriented environment, philosophy, and practices to include participant empowerment, self-sufficiency, and recovery options as defined by the participant.
- Ability to refer to hospital providing 24-hour medical backup;
- Use of clinically managed high-intensity residential service time as preparation for referral to another level of care; and
- Recognition of the chronic nature of the disease of substance dependence and the fact that some participants will require multiple admissions.

Who can claim for this service: DMHA Certified Service Provider Agencies; Free-Standing Psychiatric Inpatient Treatment Facilities shall be certified and In compliance with the Indiana Administrative Code, 440 IAC 1.5. Residential Care Providers shall be certified and In compliance with the Indiana Administrative Code, 440 IAC 6.

Exclusions: Provider shall voucher for admission day in clinically managed high-intensity residential service but **not** day of discharge. Services are all inclusive. On the day of admission, the provider may voucher for the enrollment fee and admin fee only. No additional services shall be billed during the duration of the participant's Recovery Works stay.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff. In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Providers must make every effort to bill insurance for the individual's stay. If the insurance company approves the stay after Recovery works has been billed, the provider will reimburse Recovery Works for the covered service. If additional days are necessary, providers must advocate with the insurance company for additional days (if stay was covered by insurance).

Clinically Managed Low-Intensity Residential Services (Treatment Bundle) - $126.46/unit (unit = 1 day); requires Prior Authorization – covers up to 21 days

Participants shall have a diagnosis of Substance Use Disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders current edition. This service is equivalent to the American Society of Addiction Medicine (ASAM) Level 3.1. Clinically Managed Low-Intensity Residential Services program offers room, board, and interpersonal support to individuals in substance use recovery.
Clinically managed low-intensity residential services provide an ongoing therapeutic environment for participants requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into the worlds of work, education, and family life; and building adaptive skills that may not have been achieved or have been diminished during the participant's active addiction. Services may be offered in an appropriately licensed facility located in a community setting, such as a halfway house, group home, or other supportive living environment. Clinically Managed Low-Intensity

Residential Services is provided by a health care institution other than a hospital or a nursing care institution which provides resident beds or residential units, supervisory care services, personal care service, directed care services or health-related services for persons who do not need a higher level of service according to ASAM criteria.
All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care. This service is delivered under a defined set of physician-approved policies and procedures or clinical protocols.
The purpose of clinically managed low-intensity residential services is to support, stabilize and rehabilitate individuals so they can return to independent community living. Clinically Managed Low-Intensity Residential Services provide a structured environment on a 24-hour basis.

Minimum service requirements:

- Eligible participants shall have significant impairment in physiological, social, occupational, and/or psychological functioning due to substance use. Participants may have a co-occurring disorder, defined as concurrent diagnosis of mental illness, and shall receive treatment for substance use and co-occurring disorders concurrently.
- Treatment services shall be based on individual need and diagnosis. Treatment services shall support participant self-sufficiency, decision making, empowerment, and disease self-management principles. Services include 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal
- Length of stay in clinically managed low-intensity residential services shall be determined utilizing the American Society of Addiction Medicine (ASAM) level of care criteria and requires prior approval of DMHA. Clinically managed low-intensity residential services shall have separate living areas for women and men. All services shall utilize evidence-based practices (EBP) and gender specific care. Evidence based practice is defined as programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results; show the greatest levels of effectiveness and have been replicated in different settings with different populations over time; and can include but are not limited to "treatment manuals." Evidence based practices for substance abuse is supported by the Substance Abuse and Mental Health Administration (SAMHSA): National Registry of Evidence-based Programs and Practices (NREPP). Provider shall have individualized, holistic, and comprehensive recovery/discharge plans for all participants utilizing community resources, recovery support services, and clinical interventions in the community of the participants' primary residence.
- All clinically managed low-intensity residential services shall be designed to practice and utilize recovery oriented environment, philosophy, and practices to include participant empowerment, self-sufficiency, and recovery options as defined by the participant.
- Ability to refer to hospital providing 24-hour medical backup;
- Use of clinically managed low-intensity residential services as preparation for referral to another level of care; and
- Recognition of the chronic nature of the disease of substance dependence and the fact that some participant s will require multiple admissions.
- Facilitates application of recovery skills, relapse prevention, and emotional coping skills.
- 24-hour structure and support provides residents with the opportunity to develop and practice interpersonal/group living skills, reintegrate into the community/family, and begin or resume employment and/or academic pursuits.

- Treatment Bundle must include a minimum of 5 hours of planned, clinical services of professionally directed treatment per week; the specific services and supports must be listed on the individualized plan and include a projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter and type of personnel that will be furnishing the services
- Clinical services must be individualized for each participant; services available for the treatment bundle should include, at a minimum:
    - o Case management
    - o Individual, family, and group Skills Training and Development
    - o Individual, family, and group Counseling
    - o Alcohol and Other Drug Screening
    - o Peer Recovery Support Services
    - o Medication monitoring/review; and/or access to medications

Who may claim for this service: DMHA Certified Service Provider Agencies; Free-Standing Psychiatric Inpatient Treatment Facilities shall be certified and In compliance with the Indiana Administrative Code, 440 IAC 1.5. Residential Care Providers shall be certified and In compliance with the Indiana Administrative Code, 440 IAC 6.

Exclusions: Provider shall voucher for admission day in clinically managed high-intensity residential service but **not** day of discharge. Services are all inclusive. On the day of admission, the provider may voucher for the enrollment fee and admin fee only. No additional services shall be billed during the duration of the participant's Recovery Works stay.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff. In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences including return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Providers must make every effort to bill insurance for the individual's stay. If the insurance company approves the stay after Recovery works has been billed, the provider will reimburse Recovery Works for the covered service. If additional days are necessary, providers must advocate with the insurance company for additional days (if stay was covered by insurance).

Comprehensive Mental Health and Substance Use Disorder Assessment - $130/unit (unit = 1 assessment)

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin the treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant. When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment (including ANSA)

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be completed in conjunction with the ANSA.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e. Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Comprehensive Mental Health and Substance Use Disorder Assessment - $205/unit (unit = 1 assessment) – CRIMINAL JUSTICE INSTITUTION

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin the treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment

must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant. When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment (including ANSA)

In order to claim for this service, the assessment must be performed face-to-face inside of a Criminal Justice Institution. An institution is defined as "a place where an organization takes care of people for a usually long period of time" (Merriam-Webster dictionary). Providers entering these institutions would most likely need additional security clearances; may receive professional visitor status; may receive additional security screenings; may or may not be allowed lap tops/WIFI for assessments. When Recovery Works speaks about Criminal Justice Institutions, we are speaking to facilities in which your participants cannot leave (DOC Facilities/Prison, County Jail, some Community Correction/Work Release Facilities).

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be in conjunction with the ANSA.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e. Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Comprehensive Mental Health and Substance Use Disorder Assessment - $100/unit (unit = 1 assessment) – TELEHEALTH

Designated Recovery Works Providers agree, upon acceptance of the referral, to begin the treatment process with a Comprehensive Mental Health and Substance Use Disorder Assessment. The assessment must include a DSM 5 or ICD 10 Diagnosis of Mental Health, Substance Use Disorder, or Co-Occurring; clear medical necessity for ongoing treatment; and the participant's statement of his/her individualized treatment goal. Organizations providing clinical assessment are expected to provide each participant with an in depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. The ANSA must be paired with the clinical interview. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant. When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment (including ANSA)

Tele-health is the use of a telecommunication system to provide services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Tele-health is the delivery of acute mental health or substance use care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site, known as the Originating Site.

Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications.

Service Sites
The originating site is the facility in which the participant is located. The distant site is the facility from which the provider furnishes the TMH (Tele-Mental Health) service. All distant sites must be approved Recovery Works providers.

Special Considerations
When ongoing services are provided, the participant should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the distant physician should coordinate with the patient's primary care physician.

Documentation Standards

- Documentation must be maintained at the distant and originating locations to substantiate the services provided.
- Documentation must indicate the services were rendered via TMH.
- Documentation must clearly indicate the location of the distant and originating sites.
- All documentation guidelines for services rendered via TMH apply
- Documentation is subject to post-payment review.
- Providers must have written protocols for circumstances when the participant must have a face-to-face visit with the consulting provider. The participant should always be given the choice

between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the participant must be obtained by the originating site and maintained at the distant and originating sites.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: None. ALL assessments must be done with an ANSA. Telemedicine is not the use of the following: (1) *Telephone transmitter for trans-telephonic monitoring; or* (2) *Telephone or any other means of communication for consultation from one provider to another.*

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e. Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Enrollment Administrative Fee - $50.00/unit (unit = 1 enrollment assessment)

Upon completing a comprehensive mental health and substance use disorder assessment along with the ANSA on a referred participant, Designated Recovery Works agencies may claim 1 Enrollment Administrative Fee unit per participant. This unit should be claimed at the same time as the assessment.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Exclusions: Must be claimed with an initial assessment.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file or in WITS the following:

- Date and time of assessment
- Rendering Staff performing assessment

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution.

Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Health Care Coordination Services - $8.55/unit (unit =1/4 hour)

A Community Health Worker (CHW) **i**s a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Who may claim for this service: DMHA/ISDH Certified Community Health Workers and/or Certified Recovery Specialist (CHW/CRS)

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What are the specific plans for next step, including the participants actionable items, include date, time and type of next contact
- Rendering staff name

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

HIP Power Account Contribution - $1/unit (unit = 1 dollar); requires Prior Authorization for claims exceeding $165 maximum – contribution amount varies

The Division of Mental Health and Addiction is able to contribute to a beneficiary's POWER account contribution. Funds cannot be used toward co-pays. Recovery Works funds can be used to pay the POWER account contribution for any participant in our program who expresses need, as long as the individual qualifies for, and is enrolled in, Recovery Works. All, or a portion, of the annual contribution amount may be requested in the prior authorization; however, a plan for the participant to make future contributions into the POWER account should accompany the prior authorization request.

Who may claim for this service: Designated Recovery Works Agencies

Exclusions: There are no limits on the amounts third parties can contribute to a beneficiary's POWER account except that the contribution must be used to offset the beneficiary's required contribution only - not the state's.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Intensive Outpatient Treatment- $43.74/unit (unit = 3hour group)

IOT is a treatment program that operates at least three (3) hours per day, at least three (3) days per week, and is based on an Individualized Recovery Plan. IOT is planned and organized with Substance Use professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group setting. IOT includes group therapy, interactive education groups, skills training, random drug screenings, and counseling. IOT is limited to forty (40) three (3) hour sessions; PA is required for consumers requiring additional units of service. IOT may be provided for eligible participants with a substance-related disorder and:

- Minimal or manageable medical conditions;
- Minimal or manageable withdrawal risk; or
- Emotional, behavioral and cognitive conditions that will not prevent the consumer from benefiting from this level of care.

IOT program standards include the following components:

- Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day and at least three (3) days per week.
- Referral to 12-step programs, peers, and other community supports (12 step programs are not RW billable).
- Education on Substance Use disorders.
- Skills training in communication, anger management, stress management, and relapse prevention.
- Individual, group, and family therapy (provided by a licensed professional or QBHP only).
- IOT must be offered as a distinct service.
- IOT must be individualized and a service necessary for the individual participant.

- Access to additional support services (e.g., peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated treatment, referral to other community supports) as needed.
- The participant is the focus of the service.
- Documentation must support how the service benefits the participant, including when the service is in a group setting. Individual contribution to the session is not optional documentation.
- Services must demonstrate progress toward or achievement of consumer identified treatment goals. Service goals must be rehabilitative in nature.
- Up to twenty (20) minutes of break time is allowed during each three consecutive hour session.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers; A licensed professional is responsible for the overall management of the clinical program. At least one (1) of the direct service providers must be a LAC or a LCAC.

Exclusions:

- Consumers with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Consumers at imminent risk of harm to self or others
- IOT will not be reimbursed for consumers receiving Group Substance Use Counseling on the same day.
- IOT sessions that consist of education services only are not reimbursable. Skills sessions cannot be billed or utilized as IOT services.
- Any service that is less than three hours, 3 times a week may not be billed as IOT.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant ’s status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication for Treatment of Mental Health and/or Substance Use Disorders - Requires Prior Authorization for claims exceeding the $3,000.00 maximum; Actual pharmacy expense will be reimbursed for medication; (unit = $1); must maintain receipts in record

Who can claim for this service: Psychiatrist; Licensed Physician; AHCP.
For MAT prescribers must be data waived under Indiana and Federal law.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff – individual who dispensed medication to participant

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication Assisted Treatment (OTP Treatment Bundles) – Requires Prior Authorization for services beyond Initial Intake & 10 subsequent days of dosing/services; Methadone Assisted Treatment Bundle - $16.05/unit (unit= 1 day)

Organizations providing Medication Assisted treatment are expected to provide pharmacotherapies approved by the Food and Drug Administration (FDA) for the treatment of Opioid use disorders and be recognized by the Division of Mental Health and Addictions to offer this service. All recognized protocols eligible for billing under a treatment bundle must include the statutorily required services for medication assisted opiate treatment, as well as, must include:

- Full medical physical included at initial intake
- Full DMHA approved bio-psychosocial assessment at initial intake
- Ongoing medical supervision
- Supervised medication distribution
- Regular counseling
- Regular multi-panel AOD testing, both scheduled and random
- Ongoing referrals for other needed treatment and recovery support services
- Screening and/or referral for the treatment of co-occurring mental health needs

All of these services are to be provided as one bundled service for the purpose of Recovery Works vouchers. Recovery Works vouchers will only pay for Medication Assisted Treatment in support of individual participant's recovery activities as listed in his/her individualized recovery plan.

Who can claim for this service: Indiana Opioid Treatment Programs who meet the DMHA Certification Requirements under Indiana Code 440 Article 10. Prescribers must meet licensure requirements and be data waived under Indiana and Federal law.

Billing Guidelines: Organizations billing for reimbursement of this service must receive a Prior Authorization (PA) and be able to document approval of the PA from state staff. In addition, be able to document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service.

Medication Assisted Treatment Assessment - $112.78 unit (unit = 1 assessment)

Organizations providing clinical assessment are expected to provide each participant with an in depth analysis of strengths and needs in regard to his or her mental health disorders and/or substance use disorders, and any other co-occurring medical or developmental disorders. Such analysis must be conducted through the use of an evidence-based peer-reviewed standardized assessment tool in general use for mental health populations in the State of Indiana. Upon completion of the clinical assessment, the organization shall discuss the results of the assessment and recommendations of the clinician with the participant. The assessment may also include:

- Drug testing
- Specimen collection and handling
- Hepatitis A, B, and C testing, as needed
- Pregnancy testing, as needed
- Tuberculous testing, as needed
- Syphilis testing, as needed
- Complete blood count, as needed
- Other blood testing, as needed

When documenting a claim for Recovery Works funding for a comprehensive mental health and substance use disorder assessment, the organization must document each of the following:

- Tool used in assessment
- Outcomes of the assessment

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Exclusions: None.

Billing Guidelines: Organizations billing for reimbursement of this service must document via

electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Tool used in Assessment
- Outcomes of Assessment (including ANSA results) (i.e. Treatment Plan)
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Medication Review - $23.88/unit (unit = 1/4 hr)

Psychiatric Assessment consists of a face-to-face activity that is designed to provide psychiatric assessment, consultation, and medication services to participants. Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a participant's treatment

Monitoring a participant's medical and other health issues that are either directly related to the mental health- or substance-related disorder, or to the treatment of the disorder (for example, diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures).
To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the participant's recovery plan, and documented in the clinical record in a way that reflects the complexity of the interaction.

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not

to be funded under this service category.

Medication Training & Support - Individual - $18.62/unit (unit = 1/4 hour); Group - $3.35/unit (unit = 1/4 hour); Individual/Family - $18.62/unit (unit = 1/4 hour); Family Group - $3.35/unit (unit = 1/4 hour)

Medication Training and Support involves face-to-face contact with the participant and/or family or nonprofessional caregivers in an individual setting for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non-face-to-face activities. Face-to-face contact in an individual setting with the participant and/or family or nonprofessional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects. When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option.

Who may claim for this service: The following providers may provide Medication Training and Support within the scope of practice as defined by federal and state law: Licensed physician, AHCP, RN, LPN, MA who has graduated from a two (2) year clinical program

Exclusions:

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding participant self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development.
- Medication Training and Support may not be provided for professional caregivers.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant ’s status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Mental Health Counseling - Individual - $28.65/unit (unit = 1/4 hour)

Mental Health Counseling is a planned and organized service with the participant, where mental health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant. Mental Health Counseling consists of regularly scheduled sessions.

- Mental Health Counseling may include:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development. (Batterer's Intervention Program and similar programming in not a covered service under Recovery Works.)
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Mental Health Counseling – Family/Individual- $28.65/unit (unit = 1/4 hour); Family Group - $7.16/unit (unit = 1/4 hour)

Mental Health Counseling is a planned and organized service with the participant and/or family members (as defined by participant), or nonprofessional caregivers, where Mental Health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant and/or family members. Mental Health Counseling consists of regularly scheduled sessions.

- Family Mental Health Counseling may include the following:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development. (Batterer's Intervention Program and similar programming in not a covered service under Recovery Works.)
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling must be provided in an age-appropriate setting for a participant younger than 18 years of age receiving services.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not

to be funded under this service category.

Mental Health Counseling - Group - $7.16/unit (unit = 1/4 hour)

Mental Health Counseling is a planned and organized service with the participant, where mental health professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. The participant is the focus of Mental Health Counseling. Documentation must support how Mental Health Counseling benefits the participant, including when the participant is not present. Mental Health Counseling requires face-to-face contact with the participant. Mental Health Counseling consists of regularly scheduled sessions.

- Mental Health Counseling may include:
    - Education on mental health disorders; however, Mental Health Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Mental Health Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development. (Batterer's Intervention Program and similar programming in not a covered service under Recovery Works.)
- Mental Health Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Mental Health Counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Mental Health Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals, including an LCAC with documentation of commensurate training and work experience; Qualified Behavioral Health Providers

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Peer Recovery Services - $8.55/unit (unit = 1/4 hour)

Peer Recovery Services are **individual face-to-face** services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Organizations providing Peer recovery services are required to have personnel on staff that have completed and passed the Addiction Peer Recovery Coach training or the Certified Recovery Specialist-Substance Abuse (CRS-SA). These are the **ONLY** peer recovery services certifications that are accepted by Recovery Works.

Who may claim for this service: Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for CRS or Recovery Coach. Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or QBHP.

Exclusions: Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.

- **Interventions targeted to groups are not billable as Peer Recovery Services.**
- Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services.
- Peer Recovery Services are not reimbursable for children under the age of sixteen (18).
- Peer Recovery Services that occur in a group setting are not reimbursable. **Peer Recovery Services are individual service support only.**

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Psychiatric Evaluation - $26.14/unit (unit = 1/4 hr)

Psychiatric Assessment consists of a face-to-face activity that is designed to provide psychiatric assessment, consultation, and medication services to participants. Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a participant's treatment

Monitoring a participant's medical and other health issues that are either directly related to the mental health- or substance-related disorder, or to the treatment of the disorder (for example, diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, and seizures).
To be a billable activity, consultation must be goal-oriented, focused on addressing barriers to fulfilling the participant's recovery plan, and documented in the clinical record in a way that reflects the complexity of the interaction.

Who may claim for this service: Licensed Physician; AHCP; Psychiatrist

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Recovery Residence

Recovery Residency - $15 room only/unit; $20 room and board/unit (unit = 1 day)

Organizations providing Recovery Residency are expected to provide participants with residential housing that is supportive of the participant's recovery and free of relapse triggers. Organizations must be certified by the Indiana Affiliation of Recovery Residences (INARR) and a Recovery Works designated agency. Information on the INARR certification can be found at www.INARR.org. Application for Recovery Works can be found at www.RecoveryWorks.fssa.IN.gov. Residences must provide a safe, clean, and sober environment for adults with mental health and/or substance use disorders. Additionally, they must comply with all INARR standards. Organizations may also help families in locating and securing affordable and safe housing, as needed. Additionally, assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other approved housing needs. It is required that the housing provider will develop with the participant a plan to move toward more stable housing. This plan will be established through an evaluation that the provider conducts, have measurable goals and a projected timeline for completion of goals. Recovery Works vouchers will only pay for Housing in support of an individual participant's recovery activities as listed in their individual recovery plan and budget.

Recovery Works will pay for up to $4000 for Transitional Housing Assistance. We expect Recovery Residences to have a "plan of stay" for the participant that includes titrating the individual down off Recovery Works For example, upon the fourth (4th) month, the expectation is that the participant will begin paying a portion and titrating down from Recovery Works funding, and transitioned to a more permanent living space. Another example of how this may work is that Recovery Works will pay for 3 full months, on the 4th month, RW will pay for 3 weeks, and the participant will pay for 1 week. On month 5, Recovery Works will pay for 2 weeks, and the participant will pay for 2, etc. Recovery Works staff expects that this conversation will be held with the participant at the beginning of their stay, and be part of their housing plan.

DSPs should NOT rely on WITS to track client expenditures. Total housing coverage varies based on service definition and per diem rates. DSPs should track length and stay, as well as obtain a monetary amount upon the individual arriving at the home.. An inquiry can be submitted to RW at the initial intake to determine number of days remaining.

Room Only ($15/unit) Requirements:

Recovery Residence wishing to provide room only, must have a kitchen with all necessary cooking tools and eating utensils available to residents. Cooking utensils include, but are not limited to: a refrigerator, food storage units (such as cabinets/shelves), cooking pots, cooking pans, cooking utensils (such as spatulas, spoons, ladle, knives, potato masher, grater, peeler, tongs, whisk, can opener, oven mitts, measuring spoons/cups, etc.), stove top, oven, etc. Eating utensils include, but are not limited to: a table, forks, spoons, knifes, plates, bowls, cups, etc.

Room only providers must provide:

- a bed
- 60 square feet of living space per resident
- a place to store personal items
- One (1) toilet for every four (4) individuals
- One (1) bath/shower for every six (6) individuals
- common space
- medication rules, including free administration of drugs by qualified personnel (Recovery Works participants may not be charged a few for administering medication)
- TB testing

Room and Board ($20/unit) Requirements:

INARR Certified Recovery Residences wishing to provide room and board services must provide all of their services listed above under Room Only definition, and: one (1) prepared meal per day, and resources for two (2) additional meals. The prepared meal must be prepared with purchased items, using agency funds. The resources for the additional two (2) meals can be donated resources.

Recovery Works will pay for up to $4000 for Transitional Housing Assistance. We expect

Recovery Residences to have a "plan of stay" for the participant that includes titrating the individual down off Recovery Works For example, upon the fourth (4th) month, the expectation is that the participant will begin paying a portion and titrating down from Recovery Works funding, and transitioned to a more permanent living space. Another example of how this may work is that Recovery Works will pay for 3 full months, on the 4th month, RW will pay for 3 weeks, and the participant will pay for 1 week. On month 5, Recovery Works will pay for 2 weeks, and the participant will pay for 2, etc. Recovery Works staff expects that this conversation will be held with the participant at the beginning of their stay, and be part of their housing plan.
DSPs should NOT rely on WITS to track client expenditures. Total housing coverage varies based on service definition and per diem rates. DSPs should track length and stay, as well as obtain a monetary amount upon the individual arriving at the home. An inquiry can be submitted to RW at the initial intake to determine number of days remaining.

Who may claim for this service: Agencies that have been INARR certified and have become a Recovery Works designated agency. Level IV Recovery Residences must also be DMHA Certified as an outpatient addiction provider.

Exclusions: Providers wishing to bill for room and board days of service may not use donated food for the one (1) prepared meal.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date(s) service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened during the client's days of residence
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- **If billing for one (1) week at a time, MUST include EACH day that residency was provided in the Encounter Notes section of the Encounter**
- Rendering staff – house manager

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including prosecution from local, state, and federal entities. Services that are properly funded under other programs are not to be funded under this service category.

Re-Entry Services

Re-Entry services are intended for individuals to use while in a correctional facility prior to being released into the community. This includes individuals residing in jails and/or Work Release facilities. DSP's should seek to provide only the services the participant needs to help ensure transition back into society. As of October 1, 2019, there are no longer any "pilot" programs in Recovery Works (jail pilot, work release pilot etc.). A specific rate sheet outlines the exact services that are reimbursable.

Skills Training and Development – Individual - $26.14/unit (unit = 1/4 hour); Group - $4.71/unit (unit = 1/4 hour); Individual/Family -$26.14/unit (unit = 1/4 hour); Family Group -$4.71/unit (unit = 1/4 hour)

Skills Training and Development – Individual ($26.14 per 1/4 hour) – Only the participant and rendering staff are included in the session.
Skills Training and Development – Group ($4.71 per ¼ hour) – Participant and one (1) or more individuals (non-family) are present for services at one time.
Skills Training and Development – Family ($26.14 per ¼ hour) – Participant and one (1) or more family members are present
Skills Training and Development – Family Group ($4.71 per ¼ hour) – Participant is not present for the service. The provider is meeting with the family to help provide a necessary skill or training pertinent to the participant's recovery. I.e., *Family wants to understand how to calm their family member down when he has episodes pertinent to mental health. The provider may want to meet with the family separately, to ensure they are fully trained and understand their role in the process.*

Please note - Skills Training and Development is NOT an intensive service category, and should not be utilized as a substitution to clinical services. If an individual is in need of intensive services, we encourage the DSP to work with the insurance company and advocate for an MRO package or rehabilitative package (private insurance).

Skills Training and Development involves face-to-face contact with the participant and/or family or nonprofessional caregivers that result in the participant's development of skills (for example, self-care, daily life management, or problem-solving skills), in an individual setting or group setting, directed toward eliminating psychosocial barriers. Development of skills is provided through structured interventions for attaining goals identified in the recovery plan and the monitoring of the participant's progress in achieving those skills. Participants are expected to show benefit from Skills Training and Development, with the understanding that improvement may be incremental. Skills Training and Development must result in demonstrated movement toward, or achievement of, the participant's treatment goals identified in the recovery plan. Skills Training and Development includes monitoring the impact of training acquisition (i.e. structured opportunities for participant to demonstrate skills acquisition and improved functioning as a result). Skills Training and Development aims to restore participant's abilities essential to independent living (i.e. self-care and daily life management skills). Provide skills training specific to illness self-management. May include, but not limited to the following types of services:

- Skills training in food planning and preparation, money management, and maintenance of living environment
- Training in appropriate use of community services
- Medication-related education and training by nonmedical staff
- Training in skills needed to locate and maintain a home; renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, locating and interviewing prospective roommates, and understanding renter's rights and responsibilities
- Social skills training necessary for functioning in a work and/or community environment

The participant is the focus of Skills Training and Development. Documentation must support how the service benefits the participant, including when the participant is not present. Skills Training and

Development goals are rehabilitative in nature and time limited.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers

Exclusions:

- Skills Training and Development that is habilitative in nature is not reimbursable.
- Skill-building activities not medically necessary to address the mental health and/or substance use disorder are not reimbursable.
- Activities purely for recreation or diversion are not reimbursable (see case management referrals and linkages).
- Job coaching is not reimbursable (see supportive employment services definition).
- Academic tutoring is not reimbursable (see case management referrals and linkages).
- Individual Skills Training and Development services are not reimbursable if delivered on the same day as AIRS or CAIRS.
- Skills Training and Development may not be provided to professional caregivers.

- Skills training and development cannot be used to build or employ participants within the provider organization

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling - Individual - $14.58/unit (unit = 1/4 hour)

Substance Use Disorder Counseling is a planned and organized service with the participant, where Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. Substance Use Disorder Counseling is designed to be a less intensive alternative to Intensive Outpatient Treatment. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant. Substance Use Disorder Counseling requires face-to-face contact with the participant.

Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use disorders; however, Substance Use Disorder Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, mood de-escalation, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Substance Use Disorder counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participants at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling – Family - $14.58/unit (unit = 1/4 hour); Family Group - $3.65/unit (unit = 1/4 hour) – Involves the participant and at least 1 family member

Substance Use Disorder Counseling – Family is a planned and organized service with the participant and/or family members, or nonprofessional caregivers, where Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her IRPB. Substance Use

Disorder Counseling is designed to be a less intensive alternative to IOT. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant, including when the participant is not present.
Substance Use Disorder Counseling requires face-to-face contact with the participant and/or family members. Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use disorders; however, Substance Use Disorder Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, anger management, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward and achievement of participant treatment goals identified in the IRPB.
- Substance Use Disorder counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participants at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant ’s status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Substance Use Disorder Counseling – Group - $3.65/unit (unit = 1/4 hour) – Participant plus one other individual (non-family related)

Substance Use Disorder Counseling is a planned and organized service with the participant, where

Substance Use professionals and clinicians provide counseling intervention that works toward the goals identified in his/her recovery plan. Substance Use Disorder Counseling is designed to be a less intensive alternative to Intensive Outpatient Treatment. The participant is the focus of Substance Use Disorder Counseling. Documentation must support how Substance Use Disorder Counseling benefits the participant. Substance Use Disorder Counseling requires face-to-face contact with the participant. Substance Use Disorder Counseling consists of regularly scheduled sessions.

- Substance Use Disorder Counseling may include the following:
    - Education on Substance Use disorders; however, Substance Use Disorder Counseling sessions that consist of education services only are not reimbursable.
    - Skills training in communication, mood de-escalation, stress management, and relapse prevention; however, Substance Use Disorder Counseling sessions that consist only of skills training, without process work, should be billed under Skills Training and Development.
- Substance Use Disorder Counseling must demonstrate progress toward and achievement of participant treatment goals.
- Substance Use Disorder counseling goals are rehabilitative in nature.
- A licensed professional must supervise the program and approve the content and curriculum of the program.
- Substance Use Disorder Counseling must be individualized and person centered.
- Referral to available community-based support services is expected.
- Group setting should be no larger than 12 participants.

Who may claim for this service: Licensed Professionals; Qualified Behavioral Health Providers

Exclusions:

- Participants with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services are not eligible for this service.
- Participants at imminent risk of harm to self or others are not eligible for this service.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant ’s status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.

Supported Employment Services – $9.17/unit (unit = 1/4 hour)

Supported Employment means competitive work in integrated work settings, or employment in integrated work settings, in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities

- for whom competitive employment has not traditionally occurred; or
- for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and
- who, because of the nature and severity of their disability, need intensive supported employment services for the period, and any extension, described in paragraph (36)(C) and extended services after the transition described in paragraph (13)(C) in order to perform such work.
- Such term includes transitional employment for persons who are individuals with the most significant disabilities due to mental illness.

Supported Employment Services are intended to be a placement and support program designed for adult individuals with a mental impairment for whom competitive employment has been interrupted or unattainable as a result of their disability. Due to the nature and extent of their disabilities, these individuals may benefit from placement, support, and ongoing services in order to maintain employment. Participants are provided concentrated placement, support, and ongoing services in order to gain and maintain employer and community relationships. Supported Employment Services emphasize a holistic approach to enhance the participant's strengths, talents, and abilities in order to match the needs and requirements of the business, while remaining mindful of the individual's chosen vocational goal. Supported Employment Services should assist participants with accessing resources for job applicants, including phones, internet service, resume writing support, interview tips and practice, as well as appropriate dress and presentation guidance for the workplace. The essential components of supported employment are:

- competitive employment (e.g., at least minimum wage)
- duties integrated with other employees who are not disabled
- ongoing supports to assist the individual to keep his or her job long term

Supported Employment Services are any services described in an individualized plan for employment necessary to assist an individual with a mental health and/or substance use disorder, which prevents them from otherwise obtaining employment, in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual, including—

- an assessment for determining eligibility and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology;
- counseling and guidance, including information and support services to assist an individual in exercising informed choice consistent with the provisions of section 722 (d) of 29 U.S. CODE § 722;
- referral and other services to secure needed services from other agencies through agreements developed under section 721 (a)(11) of 29 U.S. CODE § 722;

- job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;
- vocational and other training services, including the provision of personal and vocational adjustment services, books, tools, and other training materials, except that no training services provided at an institution of higher education shall be paid for with these funds;
- maintenance for additional costs incurred while participating in an assessment for determining eligibility and vocational rehabilitation needs or while receiving services under an individualized plan for employment;
- transportation, including adequate training in the use of public transportation vehicles and systems, that is provided in connection with the provision of any other service described in this section and needed by the individual to achieve an employment outcome;
- on-the-job or other related personal assistance services provided while an individual is receiving other services described in this section;
- occupational licenses, tools, equipment, and initial stocks and supplies;
- technical assistance and other consultation services to conduct market analyses, develop business plans, and otherwise provide resources, to the extent such resources are authorized to be provided through the statewide workforce investment system, to eligible individuals who are pursuing self-employment or telecommuting or establishing a small business operation as an employment outcome;
- specific post-employment services necessary to assist an individual with a disability to retain, regain, or advance in employment.

Who can claim for this service: Licensed Professionals; Qualified Behavioral Health Providers; Other Behavioral Health Providers.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant ’s status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact
- Rendering staff

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category. Please note, supported employment cannot be utilized to build or support the service provider organization.

Telepsychiatry- $23.88/unit (unit = 1/4 hour); requires Prior Authorization

Telepsychiatry is the use of a telecommunication system to provide psychiatric services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment.

Telepsychiatry is the delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site, known as the Originating Site.

Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications.

Service Sites

The originating site is the facility in which the participant is located. The distant site is the facility from which the provider furnishes the TMH service. All service sites **must** be approved Recovery Works providers.

Special Considerations

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the hub physician should coordinate with the patient's primary care physician.

Documentation Standards

- Documentation must be maintained at the hub and spoken locations to substantiate the services provided.
- Documentation must indicate the services were rendered via TMH.
- Documentation must clearly indicate the location of the hub and spoke sites.
- All documentation guidelines for services rendered via TMH apply
- Documentation is subject to post-payment review.
- Providers must have written protocols for circumstances when the member must have a hands on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the spoke site and maintained at the hub and spoke sites.

Who can claim for this service: Designated Recovery Works Agencies with Prior Authorization who follow federal and state digital health information security guidelines; Providers include Licensed Physician, Psychiatrist, AHCP.

Exclusions: Telemedicine is not the use of the following: (1) *Telephone transmitter for transtelephonic monitoring; or* (2) *Telephone or any other means of communication for consultation from one provider to another.*

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participant's actionable items, include date, time, and type of next contact

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from the return of funds paid for the services up to and including federal prosecution. Additionally, services properly funded under other Recovery Works service categories are not to be funded under this service category.

Transportation - Agency Vehicle – $10.00/unit (unit = round trip); Public Transportation - Actual expense

Organizations providing Transportation Services are expected to provide individual participants with transportation to and from recovery related activities in the form that has the most appropriate and cost effective manner. Transportation assistance can be provided in one of the following two ways: Properly registered and insured agency owned vehicle and public transportation (bus passes/tokens).

A trip is defined as transporting a Recovery Works participant from the initial point of pick-up to the drop point at the final destination. Transportation must be the least expensive type of transportation available that meets the recovery needs of the participant. Providers must bill for all transportation services provided to the same participant on the same date of service on one encounter.
If the participant is traveling to multiple destinations in succession, the provider may not bill for a trip between each point of the destination. The following offers explanation of this concept:

- **Example 1**: A vehicle picks up a participant at home and transports the participant to the psychiatrist's office. This is a one-way trip (1 unit).
- **Example 2:** A vehicle picks up a participant from home and transports the participant to the psychiatrist's office. The provider leaves, and later the same vehicle picks the participant up from the psychiatrist's office and transports the participant back to the participant's home. This is considered a round trip (1 unit).
- **Example 3**: A vehicle picks the participant up from the psychiatrist's office and transports the participant to the laboratory for a blood draw, waits outside the laboratory for the participant, and then transports the participant home. This is a one-way trip (1 unit), even though there was a stop along the way. A stop along the way is not considered a separate trip.
- **Example 4:** A vehicle picks up Participant A at the participant's home and begins to transport the Participant A to the Recovery center. Along the way, a stop is made to pick up Participant B at a Recovery home and both Participant A and Participant B are transported to the Recovery center. The stop at the Recovery home is not considered a separate trip and the transportation of

Participant A from home to the Recovery center is considered a one-way trip. If they were then picked up and returned to their recovery centers/homes, it would still be a round trip (1 unit).

When entering the encounter, for billing purposes, provider must list the initial point of pick-up and any destinations in the Encounter Note section of the encounter. Recovery Works will only reimburse the per trip unit, this program does not reimburse mileage.

Agencies providing transportation via agency owned vehicles must have on file: photo copies of Driver's Licenses, Vehicle Registration and Auto Insurance Coverage.

Exclusions: Uber, Lyft, cab, or personal vehicles are not public/agency transportation. In addition, RW cannot be billed for taking participants to and from work.

Billing Guidelines: Organizations billing for reimbursement of this service must document via electronic/paper file the following:

- Date service was rendered
- Start time and end time of service
- Report of the participant 's status on the identified outcome measures
- Description of what happened in the session
- How this interaction will assist the participant in moving forward in their recovery
- What is the specific plan for next steps, including the participants actionable items, include date, time and type of next contact.
- A plan for continued transportation services to help the participant become self-sufficient

Organizations can choose to include additional information at their discretion as long as minimal requirements are met. Inappropriate billing of this service can be construed as fraud and can result in consequences from return of the funds paid for the services up to and including federal prosecution. Additionally, services that are properly funded under other Recovery Works service categories are not to be funded under this service category.